

United States Code Annotated [Currentness](#)

Title 42. The Public Health and Welfare

 [Chapter 7. Social Security \(Refs & Annos\)](#)

→ [Subchapter XIX. Grants to States for Medical Assistance Programs \(Refs & Annos\)](#)

→ § 1396. Medicaid and CHIP payment and access Commission

(a) establishment

There is hereby established the Medicaid and CHIP payment and access Commission (in this section referred to as “MACPAC”)

(b) Duties

(1) Review of access policies and annual reports

MACPAC shall--

(A) review policies of the Medicaid program established under this subchapter (in this section referred to as “Medicaid”) and the State Children’s Health Insurance Program established under subchapter XXI of this chapter (in this section referred to as “CHIP”) affecting children’s access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress concerning such access policies;

(C) by not later than March 1 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC’s recommendations concerning such policies; and

(D) by not later than June 1 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) Specific topics to be reviewed

Specifically, MACPAC shall review and assess the following:

(A) Medicaid and CHIP payment policies

Payment policies under Medicaid and CHIP, including--

(i) the factors affecting expenditures for items and services in different sectors, including the process for updating hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries.

(B) Interaction of Medicaid and CHIP payment policies with health care delivery generally

The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this subchapter or subchapter XXI of this chapter and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(C) Other access policies

The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers.

(3) Creation of early-warning system

MACPAC shall create an early-warning system to identify provider shortage areas or any other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries.

(4) Comments on certain secretarial reports

If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(5) Agenda and additional reviews

MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this subchapter or subchapter XXI of this chapter as may be requested by such chairmen and members and as MACPAC deems appropriate.

(6) Availability of reports

MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(7) Appropriate committee of Congress

For purposes of this section, the term "appropriate committees of Congress" means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(8) Voting and reporting requirements

With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC

shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(9) Examination of budget consequences

Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

(c) Membership

(1) Number and appointment

MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) Qualifications

(A) In general

The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, health information technology, pediatric physicians, dentists, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(B) Inclusion

The membership of MACPAC shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include consumers representing children, pregnant women, the elderly, and individuals with disabilities, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) Majority nonproviders

Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) Ethical disclosure

The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 ([Public Law 95-521](#)).

(3) Terms

(A) In general

The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) Vacancies

Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) Compensation

While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under [section 5315 of Title 5](#); and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under [section 5948 of Title 5](#), and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) Chairman; Vice Chairman

The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) Meetings

MACPAC shall meet at the call of the Chairman.

(d) Director and staff; experts and consultants

Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may--

- (1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of Title 5, governing appointments in the competitive service);
- (2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;
- (3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes ([41 U.S.C. 5](#)));
- (4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) Powers

(1) Obtaining official data

MACPAC may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) Data collection

In order to carry out its functions, MACPAC shall--

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) Access of GAO to information

The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) Periodic audit

MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) Authorization of appropriations

(1) Request for appropriations

MACPAC shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) Authorization

There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

§ 1396-1. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must--

- (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;
- (2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;
- (3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;
- (4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of Title 18, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act;
- (5) either provide for the establishment or designation of a single State agency to administer or to supervise the administra-

tion of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with--

(A) the administration of the plan; and

(B) at State option, the exchange of information necessary to verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 and free or reduced price lunches under the Richard B. Russell National School Lunch Act, in accordance with section 9(b) of that Act, using data standards and formats established by the State agency;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide--

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of [section 1395aa\(a\)](#) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of [section 1395x\(e\)\(9\)](#) of this title or paragraphs (16) and (17) [\[FN1\]](#) of [section 1395x\(s\)](#) of this title, or, in the case of a laboratory which is in a rural health clinic, of [section 1395x\(aa\)\(2\)\(G\)](#) of this title;

(10) provide--

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to--

(i) all individuals--

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of [section 602\(a\)\(37\)](#) [\[FN2\]](#), [606\(h\)](#) [\[FN2\]](#), or [673\(b\)](#) of this title, or considered by the State to be receive-

ing such aid as authorized under [section 682\(e\)\(6\)](#) [\[FN2\]](#) of this title),

(II) (aa) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ([P.L. 104-193](#)) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in [section 1396d\(q\)](#) of this title), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI of this chapter if [subparagraphs \(A\) and \(B\) of section 1382\(c\)\(7\)](#) of this title were applied without regard to the phrase “the first day of the month following”,

(III) who are qualified pregnant women or children as defined in [section 1396d\(n\)](#) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) of this section for such a family; [\[FN3\]](#)

(V) who are qualified family members as defined in [section 1396d\(m\)\(1\)](#) of this title; [\[FN3\]](#)

(VI) who are described in subparagraph (C) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) of this section for such a family, or

(VII) who are described in subparagraph (D) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) of this section for such a family; [\[FN4\]](#)

(ii) at the option of the State, to [\[FN5\]](#) any group or groups of individuals described in [section 1396d\(a\)](#) of this title (or, in the case of individuals described in [section 1396d\(a\)\(i\)](#) of this title, to [\[FN5\]](#) any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but--

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment; [\[FN3\]](#)

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under [section](#)

[1396b\(f\)\(4\)\(C\)](#) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in [subsection \(c\), \(d\), or \(e\) of section 1396n](#) of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under [subsection \(c\), \(d\), or \(e\) of section 1396n](#) of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in [section 1396d\(o\)](#) of this title; [\[FN3\]](#)

(VIII) who is a child described in [section 1396d\(a\)\(i\)](#) of this title--

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter; [\[FN3\]](#)

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII); [\[FN3\]](#)

(X) who are described in subsection (m)(1) of this section; [\[FN3\]](#)

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under [section 1382e](#) or [1383c](#) of this title; [\[FN3\]](#)

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals); [\[FN3\]](#)

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with [section 9902\(2\)](#) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under [section 1396d\(q\)\(2\)\(B\)](#) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding [section 1396o](#) of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

(XIV) who are optional targeted low-income children described in [section 1396d\(u\)\(2\)\(B\)](#) of this title;

(XV) who, but for earnings in excess of the limit established under [section 1396d\(q\)\(2\)\(B\)](#) of this title, would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;

(XVI) who are employed individuals with a medically improved disability described in [section 1396d\(v\)\(1\)](#) of this title and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);

(XVII) who are independent foster care adolescents (as defined in [section 1396d\(w\)\(1\)](#) of this title), or who are within any reasonable categories of such adolescents specified by the State;

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients); or

(XIX) who are disabled children described in subsection (cc)(1) of this section;

(B) that the medical assistance made available to any individual described in subparagraph (A)--

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in [section 1396d\(a\)](#) of this title who are not described in subparagraph (A) or (E), then--

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance--

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services; and

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individuals described in section 1396d(s) of this title;

(iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1396u-3 and 1396d(p)(4) of this title, for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2010) for medicare cost-sharing described in section 1396d(p)(3)(A)(ii) of this title for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2) of this section) for qualified COBRA continuation beneficiaries described in subsection (u)(1) of this section; and

(G) that, in applying eligibility criteria of the supplemental security income program under subchapter XVI of this chapter [42 U.S.C.A. § 1381 et seq.] for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1382b of this title;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not,

by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under [section 1396o\(a\)\(2\)](#) or [\(b\)\(2\)](#) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in [section 1396d\(o\)](#) of this title to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under subchapter XVIII of this chapter, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) of this section who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in [section 1396d\(p\)\(1\)](#) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in [section 1396d\(p\)\(3\)](#) of this title), subject to the provisions of subsection (n) of this section and [section 1396o\(b\)](#) of this title, (IX) the making available of respiratory care services in accordance with subsection (e)(9) of this section shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A) of this section, provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to [section 1396r-4\(a\)\(1\)\(A\)](#) of this title, as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in [section 1396e](#) of this title shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) of this section who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2) of this section), (XIII) the medical assistance made available to an individual described in subsection (z)(1) of this section who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2) of this section), and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer;

(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section [\[FN6\]](#) (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment

would otherwise be made to the State with respect to the individual under [section 1396b](#) of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services, and (C) provide for coordination of the operations under this subchapter, including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under [section 1786](#) of this title;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide--

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which--

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with [section 1923](#)) the situation of hospitals which serve a disproportionate number of low-income patients with special needs; and

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of subchapter XVIII of this chapter and for payment of amounts under [section 1396d\(o\)\(3\)](#) of this title; except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual;

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in [section 1396o](#) of this title;

(15) provide for payment for services described in [clause \(B\)](#) or [\(C\)](#) of [section 1396d\(a\)\(2\)](#) of this title under the plan in accordance with subsection (bb) of this section;

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (l)(3), (m)(3), and (m)(4) of this section, include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter,

based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in [section 1382c](#) of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under [section 1396b\(f\)\(2\)\(B\)](#) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of [section 1396p](#) of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid,, [\[FN7\]](#) transfers of assets, and treatment of certain trusts;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases--

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in [section 303\(a\)\(4\)\(A\)\(i\)](#) and (ii) or [section 1383\(a\)\(4\)\(A\)\(i\)](#) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in [section 1396n\(b\)\(1\)](#) of this title), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under [section 1396d\(a\)\(4\)\(C\)](#) of this title, except as provided in subsection (g) of this section and in [section 1396n](#) of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide--

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in [section 1167\(1\) of Title 29](#)), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including--

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under [section 1396b\(r\)](#) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for

which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding [section 1396o](#) of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under [section 1396o](#) of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding [section 1396o](#) of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under [section 1396d\(a\)\(4\)\(B\)](#) of this title) covered under the State plan, the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall--

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--

(i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with subsection (e)(13)(D) of this section) for, or are provided, medical assistance under the State plan under this subchapter (and, at State option, child health assistance under subchapter XXI of this chapter), upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if--

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide, with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide--

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of [subsections \(b\) through \(d\) of section 1396r](#) of this title as they apply to such facilities;

(B) for including in "nursing facility services" at least the items and services specified (or deemed to be specified) by the Secretary under [section 1396r\(f\)\(7\)](#) of this title and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this subchapter; and

(D) for compliance (by the date specified in the respective sections) with the requirements of--

(i) [section 1396r\(e\)](#) of this title;

(ii) [section 1396r\(g\)](#) of this title (relating to responsibility for survey and certification of nursing facilities); and

(iii) [sections 1396r\(h\)\(2\)\(B\)](#) and [1396r\(h\)\(2\)\(D\)](#) of this title (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in [section 1396g](#) of this title, for the licensing of administrators of nursing homes;

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in [section 1396b\(i\)\(4\)](#) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

(B) provide, under the program described in subparagraph (A), that--

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases;

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide, with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that--

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an as-

signment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically replaces the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide--

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in [section 1396r\(g\)](#) of this title, the State or local agency utilized by the Secretary for the purpose specified in the first sentence of [section 1395aa\(a\)](#) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in [section 1320a-3\(a\)\(2\)](#) of this title) receiving payments under such plan complies with the requirements of [section 1320a-3](#) of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with

regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in [section 1320a-7\(b\)\(9\)](#) of this title;

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to [section 1320a-7](#) or [section 1320a-7a](#) of this title, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under [section 1320a\(a\)](#) of this title to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;

(42) provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan;

(43) provide for--

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in [section 1396d\(a\)\(4\)\(B\)](#) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in [section 1396d\(r\)](#) of this title and the need for age-appropriate immunizations against vaccine-preventable diseases,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of

eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

- (i) the number of children provided child health screening services,
- (ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),
- (iii) the number of children receiving dental services, and other information relating to the provision of dental services to such children described in [section 1397hh\(e\)](#) of this title, and
- (iv) the State's results in attaining the participation goals set for the State under [section 1396d\(r\)](#) of this title;

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan--

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under [section 1396b\(g\)\(6\)](#) of this title (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with [section 1396k](#) of this title;

(46)(A) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of [section 1320b-7](#) of this title; and

(B) provide, with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this subchapter, that the state shall satisfy the requirements of--

(i) [section 1396b\(x\)](#) of this title; or

(ii) subsection (ee);

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with [section 1396r-1](#) of this title and provide for making medical assistance for items and services described in subsection(a) of [section 1396r-1a](#) of this title available to children during a presumptive

eligibility period in accordance with such section and provide for making medical assistance available to individuals described in [subsection \(a\) of section 1396r-1b](#) of this title during a presumptive eligibility period in accordance with such section;

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with [section 1396r-2](#) of this title;

(50) provide, in accordance with subsection (q) of this section, for a monthly personal needs allowance for certain institutionalized individuals and couples;

(51) meet the requirements of [section 1396r-5](#) of this title (relating to protection of community spouses);

(52) meet the requirements of [section 1396r-6](#) of this title (relating to extension of eligibility for medical assistance);

(53) provide--

(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in [section 1786](#) of this title), or children below the age of 5, of the availability of benefits furnished by the special supplemental nutrition program under such section, and

(B) for referring any such individual to the State agency responsible for administering such program;

(54) in the case of a State plan that provides medical assistance for covered outpatient drugs (as defined in [section 1396r-8\(k\)](#) of this title), comply with the applicable requirements of [section 1396r-8](#) of this title;

(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX) of this section--

(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of subchapter IV of this chapter and which include facilities defined as disproportionate share hospitals under [section 1396r-4\(a\)\(1\)\(A\)](#) of this title and Federally-qualified health centers described in [section 1396d\(1\)\(2\)\(B\) \[FN8\]](#) of this title, and

(B) using applications which are other than those used for applications for aid under such part;

(56) provide, in accordance with subsection (s) of this section, for adjusted payments for certain inpatient hospital services;

(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or medicaid managed care organization (as defined in [section 1396b\(m\)\(1\)\(A\)](#) of this title) receiving funds under the plan shall comply with the requirements of subsection (w) of this section;

(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w) of this section;

(59) maintain a list (updated not less often than monthly, and containing each physician's unique identifier provided under the system established under subsection (x) of this section) of all physicians who are certified to participate under the State plan;

(60) provide that the State agency shall provide assurances satisfactory to the Secretary that the State has in effect the laws relating to medical child support required under [section 1396g-1](#) of this title;

(61) provide that the State must demonstrate that it operates a medicaid fraud and abuse control unit described in [section 1396b\(q\)](#) of this title that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary, unless the State demonstrates to the satisfaction of the Secretary that the effective operation of such a unit in the State would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the State plan, and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of medical assistance under the plan without the existence of such a unit;

(62) provide for a program for the distribution of pediatric vaccines to program-registered providers for the immunization of vaccine-eligible children in accordance with [section 1396s](#) of this title;

(63) provide for administration and determinations of eligibility with respect to individuals who are (or seek to be) eligible for medical assistance based on the application of [section 1396u-1](#) of this title;

(64) provide, not later than 1 year after August 5, 1997, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this subchapter;

(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in [section 1395x\(n\)](#) of this title, and the State shall not issue or renew such a supplier number for any such supplier unless--

(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in [section 1320a-3\(a\)\(3\)](#) of this title) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in [section 1320a-3\(a\)\(2\)](#) of this title) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) a surety bond in a form specified by the Secretary under [section 1395m\(a\)\(16\)\(B\)](#) of this title and in an amount that is not less than \$50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section;

(66) provide for making eligibility determinations under section 1936u-5 of this section;

(67) provide, with respect to services covered under the State plan (but not under subchapter XVIII of this chapter) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract or other agreement with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary);

(68) provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall--

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under [sections 3729](#) through [3733 of Title 31](#), administrative remedies for false claims and statements established under chapter 38 of Title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in [section 1320a-7b\(f\)](#) of this title);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under [section 1396u-6](#) of this title;

(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which--

(A) may include a wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation, and such other transportation as the Secretary determines appropriate; and

(B) may be conducted under contract with a broker who--

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under [section 1395nn](#) of this title and such other prohibitions and requirements as the Secretary determines to be appropriate);

(71) provide that the State will implement an asset verification program as required under [section 1396w](#) of this title;

(72) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services; and

(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health

care services, provide for a process under which the state seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this subchapter that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that--

(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this subchapter.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). The provisions of [paragraphs \(9\)\(A\), \(31\), and \(33\) and of section 1396b\(i\)\(4\)](#) of this title shall not apply to a religious nonmedical health care institution (as defined in [section 1395x\(ss\)\(1\)](#) of this title).

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter and who for such month was entitled to monthly insurance benefits under subchapter II of this chapter shall for purposes of this subchapter only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under subchapter II of this chapter resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this subchapter, any child who meets the requirements of [paragraph \(1\) or \(2\) of section 673\(b\)](#) of this title shall be deemed to be a dependent child as defined in [section 606](#) of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of subchapter IV of this chapter in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with [section 1396b\(v\)](#) of this title.

(b) Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan--

(1) an age requirement of more than 65 years; or

(2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the

residence is maintained permanently or at a fixed address; or

(3) any citizenship requirement which excludes any citizen of the United States.

(c) Lower payment levels or applying for benefits as condition of applying for, or receiving, medical assistance

Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if the State requires individuals described in subsection (l)(1) of this section to apply for assistance under the State program funded under part A of subchapter IV of this chapter as a condition of applying for or receiving medical assistance under this subchapter.

(d) Performance of medical or utilization review functions

If a State contracts with an entity which meets the requirements of [section 1320c-1](#) of this title, as determined by the Secretary, or a utilization and quality control peer review organization having a contract with the Secretary under part B of subchapter XI of this chapter for the performance of medical or utilization review functions required under this subchapter of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of subchapter XI of this chapter and provides for such assurances of satisfactory performance by an entity or organization as the Secretary may prescribe.

(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan; individuals enrolled with health maintenance organizations; persons deemed recipients of supplemental security income or State supplemental payments; entitlement for certain newborns; postpartum eligibility for pregnant women

(1)(A) Notwithstanding any other provision of this subchapter, effective January 1, 1974, subject to subparagraph (B) each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter during the period beginning on April 1, 1990, and ending on December 31, 2010. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of subchapter IV of this chapter and have earned income, see [section 1396r-6](#) of this title.

(2)(A) In the case of an individual who is enrolled with a medicaid managed care organization (as defined in [section 1396b\(m\)\(1\)\(A\)](#) of this title), with a primary care case manager (as defined in [section 1396d\(t\)](#) of this title), or with an eligible organization with a contract under [section 1395mm](#) of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under [section 1396d\(a\)\(4\)\(C\)](#) of this title, only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.

(B) For purposes of subparagraph (A), the term “minimum enrollment period” means, with respect to an individual's enrollment with an organization or entity under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization or entity becomes effective.

(3) At the option of the State, any individual who--

(A) is 18 years of age or younger and qualifies as a disabled individual under [section 1382c\(a\)](#) of this title;

(B) with respect to whom there has been a determination by the State that--

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible for medical assistance under the State plan under this subchapter,

shall be deemed, for purposes of this subchapter only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under subchapter XVI of this chapter.

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires). Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to [section 1396b\(v\)](#) of this title, the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth.

(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

(6) In the case of a pregnant woman described in subsection (a)(10) of this section who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the woman shall be deemed to continue to be an individual described in subsection (a)(10)(A)(i)(IV) of this section and subsection (l)(1)(A) of this section without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to [section 1396r-1](#) of this title during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.

(7) In the case of an infant or child described in subparagraph (B), (C), or (D) of subsection (1)(1) of this section or [paragraph \(2\) of section 1396d\(n\)](#) of this title--

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection,

the infant or child shall continue to be treated as an individual described in such respective provision until the end of the stay for which the inpatient services are furnished.

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in [section 1396d\(p\)\(1\)](#) of this title), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under [section 1396b\(a\)](#) of this title, such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who--

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing facility, or intermediate care facility for the mentally retarded and would be eligible to have payment made for such inpatient care under the State plan;

(iv) has adequate social support services to be cared for at home; and

(v) wishes to be cared for at home.

(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, nursing facilities, or intermediate care facilities for the mentally retarded.

(C) For purposes of this paragraph, respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of subchapter IV of this chapter pursuant to [section 602\(a\)\(43\) \[FN2\]](#) of this title shall not be construed as denying (or permitting a State to deny) medical assistance under this subchapter to such individual, child, or woman who is eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(B) If an individual, child, or pregnant woman is receiving aid under part A of subchapter IV of this chapter and such aid is terminated pursuant to [section 602\(a\)\(43\) \[FN2\]](#) of this title, the State may not discontinue medical assistance under this subchapter for the individual, child, or woman until the State has determined that the individual, child, or woman is not eli-

gible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(11)(A) In the case of an individual who is enrolled with a group health plan under [section 1396e](#) of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

(B) For purposes of subparagraph (A), the term “minimum enrollment period” means, with respect to an individual's enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual's enrollment under the plan becomes effective.

(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) of this section shall remain eligible for those benefits until the earlier of--

(A) the end of a period (not to exceed 12 months) following the determination; or

(B) the time that the individual exceeds that age.

(13) Express Lane option

(A) In general

(i) Option to use a finding from an Express Lane agency

At the option of the State, the State plan may provide that in determining eligibility under this subchapter for a child (as defined in subparagraph (G)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (F)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this subchapter. The State may rely on a finding from an Express Lane agency notwithstanding subsection (a)(46)(B) of this section and 1320b-7(d) of this title or any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

(I) Prohibition on determining children ineligible for coverage

If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this subchapter and for child health assistance under subchapter XXI of this chapter, the State shall determine eligibility for assistance using its regular procedures.

(II) Notice requirement

For any child who is found eligible for medical assistance under the State plan under this subchapter or child health assistance under subchapter XXI of this chapter and who is subject to premiums based on an Express Lane agency's finding of such child's income level, the State shall provide notice that the child may qualify for lower premium payments if evaluated by the State using its regular policies and of the procedures for requesting such an evaluation.

(III) Compliance with screen and enroll requirement

The State shall satisfy the requirements under [subparagraphs \(A\)](#) and [\(B\) of section 1397bb\(b\)\(3\)](#) of this title (relating

to screen and enroll) before enrolling a child in child health assistance under subchapter XXI of this chapter. At its option, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

(IV) Verification of citizenship or Nationality status

The State shall satisfy the requirements of subsection (a)(46)(B) of this section or 1397ee(c)(9) of this title, as applicable for verifications of citizenship or nationality status.

(V) Coding

The State meets the requirements of subparagraph (E).

(ii) Option to apply to renewals and redeterminations

The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

(B) Rules of construction

Nothing in this paragraph shall be construed--

(i) to limit or prohibit a State from taking any actions otherwise permitted under this subchapter or subchapter XXI of this chapter in determining eligibility for or enrolling children into medical assistance under this subchapter or child health assistance subchapter XXI of this chapter XXI; or

(ii) to modify the limitations in subsection (a)(5) of this section concerning the agencies that may make a determination of eligibility for medical assistance under this subchapter.

(C) Options for satisfying the screen and enroll requirement

(i) In general

With respect to a child whose eligibility for medical assistance under this subchapter or for child health assistance under subchapter XXI of this chapter has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under [subparagraphs \(A\) and \(B\) of section 1397bb\(b\)\(3\)](#) of this title (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

(ii) Establishing a screening threshold

(I) In general

Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this subchapter to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this subchapter.

(II) Children with income not above threshold

If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this subchapter regardless of whether such child would otherwise satisfy such criteria.

(III) Children with income above threshold

If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in [section 1397jj\(b\)\(4\)](#) of this title and to satisfy the requirement under [section 1397jj\(b\)\(1\)\(C\)](#) of this title (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is enrolled in child health assistance under subchapter XXI of this chapter, the State shall provide the parent, guardian, or custodial relative with the following:

(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this subchapter if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian, or custodial relative can request that the State evaluate the child's eligibility for medical assistance under this subchapter using such regular procedures.

(bb) A description of differences between the medical assistance provided under this subchapter and child health assistance under subchapter XXI of this chapter, including differences in cost-sharing requirements and covered benefits.

(iii) Temporary enrollment in CHIP pending screen and enroll

(I) In general

Under this clause, a State enrolls a child in child health assistance under subchapter XXI of this chapter for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

(II) Determination of eligibility

During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under subchapter XXI of this chapter or for medical assistance under this subchapter in accordance with this clause.

(III) Prompt follow up

In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this subchapter or child health assistance under subchapter XXI of this chapter pursuant to [subparagraphs \(A\) and \(B\) of section 1397bb\(b\)\(3\)](#) of this title (relating to screen and enroll).

(IV) Requirement for simplified determination

In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

(V) Availability of CHIP matching funds during temporary enrollment period

Medical assistance for items and services that are provided to a child enrolled in subchapter XXI of this chapter during a temporary enrollment period under this clause shall be treated as child health assistance under such subchapter.

(D) Option for automatic enrollment

(i) In general

The State may initiate and determine eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan without a program application from, or on behalf of, the child based on data obtained from sources other than the child (or the child's family), but a child can only be automatically enrolled in the State Medicaid plan or the State CHIP plan if the child or the family affirmatively consents to being enrolled through affirmation in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary or by signature on an Express Lane agency application, if the requirement of clause (ii) is met.

(ii) Information requirement

The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under [section 1396k\(a\)](#) of this title) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

(E) Coding; application to enrollment error rates

(i) In general

For purposes of subparagraph (A)(iv), the requirement of this subparagraph for a State is that the State agrees to--

(I) assign such codes as the Secretary shall require to the children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency for the duration of the State's election under this paragraph;

(II) annually provide the Secretary with a statistically valid sample (that is approved by Secretary) of the children enrolled in such plans through reliance on such a finding by conducting a full Medicaid eligibility review of the children identified for such sample for purposes of determining an eligibility error rate (as described in clause (iv)) with respect to the enrollment of such children (and shall not include such children in any data or samples used for purposes of complying with a Medicaid Eligibility Quality Control (MEQC) review or a payment error rate measurement (PERM) requirement);

(III) submit the error rate determined under subclause (II) to the Secretary;

(IV) if such error rate exceeds 3 percent for either of the first 2 fiscal years in which the State elects to apply this paragraph, demonstrate to the satisfaction of the Secretary the specific corrective actions implemented by the State to improve upon such error rate; and

(V) if such error rate exceeds 3 percent for any fiscal year in which the State elects to apply this paragraph, a reduction in the amount otherwise payable to the State under [section 1396b\(a\)](#) of this title for quarters for that fiscal year, equal to the total amount of erroneous excess payments determined for the fiscal year only with respect to the children in-

cluded in the sample for the fiscal year that are in excess of a 3 percent error rate with respect to such children.

(ii) No punitive action based on error rate

The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

(iii) Rule of construction

Nothing in this paragraph shall be construed as relieving a State that elects to apply this paragraph from being subject to a penalty under [section 1396b\(u\)](#) of this title, for payments made under the State Medicaid plan with respect to ineligible individuals and families that are determined to exceed the error rate permitted under that section (as determined without regard to the error rate determined under clause (i)(II)).

(iv) Error rate defined

In this subparagraph, the term "error rate" means the rate of erroneous excess payments for medical assistance (as defined in [section 1396b\(u\)\(1\)\(D\)](#) of this title) for the period involved, except that such payments shall be limited to individuals for which eligibility determinations are made under this paragraph and except that in applying this paragraph under subchapter XXI of this chapter, there shall be substituted for references to provisions of this subchapter corresponding provisions within subchapter XXI of this chapter.

(F) Express Lane agency

(i) In general

In this paragraph, the term "Express Lane agency" means a public agency that--

(I) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making the determinations of one or more eligibility requirements described in subparagraph (A)(i);

(II) is identified in the State Medicaid plan or the State CHIP plan; and

(III) notifies the child's family--

(aa) of the information which shall be disclosed in accordance with this paragraph;

(bb) that the information disclosed will be used solely for purposes of determining eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan; and

(cc) that the family may elect to not have the information disclosed for such purposes; and

(IV) enters into, or is subject to, an interagency agreement to limit the disclosure and use of the information disclosed.

(ii) Inclusion of specific public agencies

Such term includes the following:

(I) A public agency that determines eligibility for assistance under any of the following:

(aa) The temporary assistance for needy families program funded under part A of subchapter IV of this chapter.

(bb) A State program funded under part D of subchapter IV of this chapter.

(cc) The State Medicaid plan.

(dd) The State CHIP plan.

(ee) The Food and Nutrition Act of 2008 ([7 U.S.C. 2011 et seq.](#)).

(ff) The Head Start Act ([42 U.S.C. 9801 et seq.](#)).

(gg) The Richard B. Russell National School Lunch Act ([42 U.S.C. 1751 et seq.](#)).

(hh) The Child Nutrition Act of 1966 ([42 U.S.C. 1771 et seq.](#)).

(ii) The Child Care and Development Block Grant Act of 1990 ([42 U.S.C. 9858 et seq.](#)).

(jj) The Stewart B. McKinney Homeless Assistance Act ([42 U.S.C. 11301 et seq.](#)).

(kk) The United States Housing Act of 1937 ([42 U.S.C. 1437 et seq.](#)).

(ll) The Native American Housing Assistance and Self-Determination Act of 1996 ([25 U.S.C. 4101 et seq.](#)).

(II) A State-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the State.

(III) A public agency that is subject to an interagency agreement limiting the disclosure and use of the information disclosed for purposes of determining eligibility under the State Medicaid plan or the State CHIP plan.

(iii) Exclusions

Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under subchapter XX of this chapter or a private, for-profit organization.

(iv) Rules of construction

Nothing in this paragraph shall be construed as--

(I) exempting a State Medicaid agency from complying with the requirements of subsection (a)(4) of this section relating to merit-based personnel standards for employees of the State Medicaid agency and safeguards against conflicts of interest); or

(II) authorizing a State Medicaid agency that elects to use Express Lane agencies under this subparagraph to use the Express Lane option to avoid complying with such requirements for purposes of making eligibility determinations under the State Medicaid plan.

(v) Additional definitions

In this paragraph:

(I) State

The term “State” means 1 of the 50 States or the District of Columbia.

(II) State CHIP agency

The term “State CHIP agency” means the State agency responsible for administering the State CHIP plan.

(III) State CHIP plan

The term “State CHIP plan” means the State child health plan established under subchapter XXI of this chapter and includes any waiver of such plan.

(IV) State Medicaid agency

The term “State Medicaid agency” means the State agency responsible for administering the State Medicaid plan.

(V) State Medicaid plan

The term “State Medicaid plan” means the State plan established under subchapter XIX of this chapter and includes any waiver of such plan.

(G) Child defined

For purposes of this paragraph, the term “child” means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.

(H) State option to rely on State income tax data or return

At the option of the State, a finding from an Express Lane agency may include gross income or adjusted gross income shown by State income tax records or returns.

(I) Application

This paragraph shall not apply with respect to eligibility determinations made after September 30, 2013.

(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section and [section 1382h\(b\)\(3\)](#) of this title and [section 1396r-5](#) of this title, except with respect to qualified disabled and working individuals (described in [section 1396d\(s\)](#) of this title), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with [section 1396b\(f\)](#) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(g) Reduction of aid or assistance to providers of services attempting to collect from beneficiary in violation of third-party provisions

In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C) of this section.

(h) Payments for hospitals serving disproportionate number of low-income patients and for home and community care

Nothing in this subchapter (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this subchapter for home and community care.

(i) Termination of certification for participation of and suspension of State payments to intermediate care facilities for the mentally retarded

(I) In addition to any other authority under State law, where a State determines that a [\[FN9\]](#) intermediate care facility for the mentally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this subchapter and further determines that the facility's deficiencies--

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under this subchapter, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate **(A)** when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this subchapter, or **(B)** in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause **(B)** of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Waiver or modification of subchapter requirements with respect to medical assistance program in American Samoa

Notwithstanding any other requirement of this subchapter, the Secretary may waive or modify any requirement of this subchapter with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in [section 1308\(f\)](#) of this title, or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in a numbered paragraph of [section 1396d\(a\)](#) of this title.

(k) Repealed. Pub.L. 103-66, Title XIII, § 13611(d)(1)(C), Aug. 10, 1993, 107 Stat. 627

(l) Description of group

(1) Individuals described in this paragraph are--

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age,

(C) children who have attained one year of age but have not attained 6 years of age, and

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age,

who are not described in any of subclauses **(I)** through **(III)** of subsection (a)(10)(A)(i) of this section and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with [section 9902\(2\)](#) of this title) applicable to a family of the size involved.

(ii) The percentage provided under this clause, with respect to eligibility for medical assistance on or after--

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii), and

(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).

(iii) In the case of a State which, as of July 1, 1988, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than--

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of July 1, 1988, or

(II) if no such percentage is specified as of July 1, 1988, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii)(I) to exceed 100 percent.

(iv) In the case of a State which, as of December 19, 1989, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than--

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of December 19, 1989, or

(II) if no such percentage is specified as of December 19, 1989, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.

(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(3) Notwithstanding subsection (a)(17) of this section, for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX) of this section--

(A) application of a resource standard shall be at the option of the State;

(B) any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under subchapter XVI of this chapter;

(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), or (D) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of subchapter IV of this chapter;

(D) the income standard to be applied is the appropriate income standard established under paragraph (2); and

(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of subchapter IV of this chapter (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17) of this section), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under [section 1315](#) of this title, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) of this section and for children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII) of this section in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this subchapter.

(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII) of this section and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.

(m) Description of individuals

(1) Individuals described in this paragraph are individuals--

(A) who are 65 years of age or older or are disabled individuals (as determined under [section 1382c\(a\)\(3\)](#) of this title),

(B) whose income (as determined under [section 1382a](#) of this title for purposes of the supplemental security income program, except as provided in paragraph 2(C)) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under [section 1382b](#) of this title for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with [section 9902\(2\)](#) of this title) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) of this section and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A) of this section.

(C) The provisions of [section 1396d\(p\)\(2\)\(D\)](#) of this title shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under [section 1396d\(p\)](#) of this title.

(3) Notwithstanding subsection (a)(17) of this section, for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X) of this section--

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in [section 1382a\(b\)\(4\)\(B\)\(ii\)](#) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

(4) Notwithstanding subsection (a)(17) of this section, for qualified medicare beneficiaries described in [section 1396d\(p\)\(1\)](#) of this title--

(A) the income standard to be applied is the income standard described in [section 1396d\(p\)\(1\)\(B\)](#) of this title, and

(B) except as provided in [section 1382a\(b\)\(4\)\(B\)\(ii\)](#) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17) of this section, require or permit such treatment for other individuals.

(n) Payment amounts

(1) In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under subchapter XVIII of this chapter for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)--

(A) for purposes of applying any limitation under subchapter XVIII of this chapter on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under subchapter XVIII of this chapter plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in [section 1396b\(m\)\(1\)\(A\)](#) of this title for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this subchapter or subchapter XVIII of this chapter shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

(o) Certain benefits disregarded for purposes of determining post-eligibility contributions

Notwithstanding any provision of subsection (a) of this section to the contrary, a State plan under this subchapter shall provide that any supplemental security income benefits paid by reason of [subparagraph \(E\)](#) or [\(G\) of section 1382\(e\)\(1\)](#) of this title to an individual who--

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,

will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

(p) Exclusion power of State; exclusion as prerequisite for medical assistance payments; “exclude” defined

(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary could exclude the individual or entity from participation in a program under subchapter XVIII of this chapter under [section 1320a-7](#), [1320a-7a](#), or [1395cc\(b\)\(2\)](#) of this title.

(2) In order for a State to receive payments for medical assistance under [section 1396b\(a\)](#) of this title, with respect to payments the State makes to a medicaid managed care organization (as defined in [section 1396b\(m\)](#) of this title) or to an entity furnishing services under a waiver approved under [section 1396n\(b\)\(1\)](#) of this title, the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that--

(A) could be excluded under [section 1320a-7\(b\)\(8\)](#) of this title (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions),

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in [section 1320a-7\(b\)\(8\)\(B\)](#) of this title, or

(C) employs or contracts with any individual or entity that is excluded from participation under this subchapter under [section 1320a-7](#) or [1320a-7a](#) of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(3) As used in this subsection, the term “exclude” includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

(q) Minimum monthly personal needs allowance deduction; “institutionalized individual or couple” defined

(1)(A) In order to meet the requirement of subsection (a)(50) of this section, the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance--

- (i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and
 - (ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).
- (B)** In this subsection, the term “institutionalized individual or couple” means an individual or married couple--
- (i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this subchapter throughout a month, and
 - (ii) who is or are determined to be eligible for medical assistance under the State plan.
- (2) The minimum monthly personal needs allowance described in this paragraph [\[FN10\]](#) is \$30 for an institutionalized individual and \$60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).
- (r) Disregarding payments for certain medical expenses by institutionalized individuals
- (1)(A)** For purposes of sections 1396a(a)(17) and [1396r-5\(d\)\(1\)\(D\)](#) of this title and for purposes of a waiver under [section 1396n](#) of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including--
- (i) medicare and other health insurance premiums, deductibles, or coinsurance, and;
 - (ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.
- (B)(i)** In the case of a veteran who does not have a spouse or a child, if the veteran--
- (I)** receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this title, a veteran's pension in excess of \$90 per month, and
- (II)** resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to [section 1741\(a\) of Title 38](#),
- any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of \$90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.
- (ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.
- (2)(A)** The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) of this section or under [section 1396d\(p\)](#) of this title may be less restrictive, and shall be no more restrictive, than the methodology--

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under subchapter XVI of this chapter, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10) of this section, methodology is considered to be “no more restrictive” if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(s) Adjustment in payment for hospital services furnished to low-income children under age of 6 years

In order to meet the requirements of subsection (a)(55) [\[FN11\]](#) of this section, the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in [section 1396r-4\(b\)\(1\)](#) of this title, shall--

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

(t) Limitation on payments to States for expenditures attributable to taxes

Nothing in this subchapter (including [sections 1396b\(a\)](#) and [1396d\(a\)](#) of this title) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes of general applicability imposed with respect to the provision of such items or services.

(u) Qualified COBRA continuation beneficiaries

(1) Individuals described in this paragraph are individuals--

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)).

(B) whose income (as determined under [section 1382a](#) of this title for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with [section 9902\(2\)](#) of this title) applicable to a family of the size involved,

(C) whose resources (as determined under [section 1382b](#) of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in ex-

penditures under this subchapter resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

(2) For purposes of subsection (a)(10)(F) of this section and this subsection, the term “COBRA premiums” means the applicable premium imposed with respect to COBRA continuation coverage.

(3) In this subsection, the term “COBRA continuation coverage” means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act [[42 U.S.C.A. § 300bb-1 et seq.](#)] [section 4980B of the Internal Revenue Code](#) of 1986, or title VI of the Employee Retirement Income Security Act of 1974 [[29 U.S.C.A. § 1161 et seq.](#)]

(4) Notwithstanding subsection (a)(17) of this section, for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI) of this section--

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in [section 1382a\(b\)\(4\)\(B\)\(ii\)](#) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17) of this section, require or permit such treatment for other individuals.

(v) State agency disability and blindness determinations for medical assistance eligibility

A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in [section 1382c\(a\)](#) of this title.

(w) Maintenance of written policies and procedures respecting advance directives

(1) For purposes of subsection (a)(57) of this section and [sections 1396b\(m\)\(1\)\(A\)](#) and [1396r\(c\)\(2\)\(E\)](#) of this title, the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization--

(A) to provide written information to each such individual concerning--

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the provider's or organization's written policies respecting the implementation of such rights;

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual--

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of a medicaid managed care organization, at the time of enrollment of the individual with the organization.

(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

(4) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(5) For construction relating to this subsection, see [section 14406](#) of this title (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(x) Physician identifier system; establishment

The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this subchapter.

(y) Intermediate sanctions for psychiatric hospitals

(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in [section 1396d\(h\)](#) of this title) and further finds that the hospital's deficiencies--

(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this subchapter--

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under [section 1396b\(a\)](#) of this title with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this subchapter.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if--

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable.

(z) Optional coverage of TB-related services

(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i) of this section--

(A) who are infected with tuberculosis;

(B) whose income (as determined under the State plan under this subchapter with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) of this section may have and obtain medical assistance under the plan; and

(C) whose resources (as determined under the State plan under this subchapter with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) of this section may have and obtain medical assistance under the plan.

(2) For purposes of subsection (a)(10) of this section, the term "TB-related services" means each of the following services relating to treatment of infection with tuberculosis:

(A) Prescribed drugs.

(B) Physicians' services and services described in [section 1396d\(a\)\(2\)](#) of this title.

(C) Laboratory and X-ray services (including services to confirm the presence of infection).

(D) Clinic services and Federally-qualified health center services.

(E) Case management services (as defined in [section 1396n\(g\)\(2\)](#) of this title).

(F) Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs.

(aa) Certain breast or cervical cancer patients

Individuals described in this subsection are individuals who

(1) are not described in subsection (a)(10)(A)(i);

(2) have not attained age 65;

(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act ([42 U.S.C. 300k et seq.](#)) in accordance with the requirements of [section 300n](#) of this title and need treatment for breast or cervical cancer; and

(4) are not otherwise covered under creditable coverage, as defined in [section 300gg\(c\)](#) of this title, but applied without regard to paragraph (1)(F) of such section.

(bb) Payment for services provided by Federally-qualified health centers and rural health clinics

(1) In general

Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in [section 1396d\(a\)\(2\)\(C\)](#) of this title furnished by a Federally-qualified health center and services described in [section 1396d\(a\)\(2\)\(B\)](#) of this title furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) Fiscal year 2001

Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under [section 1395l\(a\)\(3\)](#) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under [section 1395l\(a\)\(3\)](#) of this title, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) Fiscal year 2002 and succeeding fiscal years

Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year--

(A) increased by the percentage increase in the MEI (as defined in [section 1395u\(i\)\(3\)](#) of this title) applicable to primary care services (as defined in [section 1395u\(i\)\(4\)](#) of this title) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) Establishment of initial year payment amount for new centers or clinics

In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in [section 1396d\(a\)\(2\)\(C\)](#) of this title furnished by the center or services described in [section 1396d\(a\)\(2\)\(B\)](#) of this title furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) Administration in the case of managed care

(A) In general

In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in [section 1396u-2\(a\)\(1\)\(B\)](#) of this title), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(B) Payment schedule

The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) Alternative payment methodologies

Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in [section 1396d\(a\)\(2\)\(C\)](#) of this title or to a rural health clinic for services described in [section 1396d\(a\)\(2\)\(B\)](#) of this title in an amount which is determined under an alternative payment methodology that--

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

(cc)(1) Individuals described in this paragraph are individuals--

(A) who are children who have not attained 19 years of age and are born--

(i) on or after January 1, 2001 (or, at the option of a State, on or after an earlier date), in the case of the second, third, and fourth quarters of fiscal year 2007;

(ii) on or after October 1, 1995 (or, at the option of a State, on or after an earlier date), in the case of each quarter of fiscal year 2008; and

(iii) after October 1, 1989, in the case of each quarter of fiscal year 2009 and each quarter of any fiscal year thereafter;

(B) who would be considered disabled under [section 1382c\(a\)\(3\)\(C\)](#) of this title (as determined under subchapter XVI of this chapter for children but without regard to any income or asset eligibility requirements that apply under such subchapter with respect to children); and

(C) whose family income does not exceed such income level as the State establishes and does not exceed--

(i) 300 percent of the poverty line (as defined in [section 1397jj\(c\)\(5\)](#) of this title) applicable to a family of the size involved; or

(ii) such higher percent of such poverty line as a State may establish, except that--

(I) any medical assistance provided to an individual whose family income exceeds 300 percent of such poverty line may only be provided with State funds; and

(II) no Federal financial participation shall be provided under [section 1396b\(a\)](#) of this title for any medical assistance provided to such an individual.

(2)(A) If an employer of a parent of an individual described in paragraph (1) offers family coverage under a group health plan (as defined in section 2791(a) of the Public Health Service Act), the State shall

(i) notwithstanding [section 1396e](#) of this title, require such parent to apply for, enroll in, and pay premiums for such coverage as a condition of such parent's child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) of this section if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

(ii) if such coverage is obtained--

(I) subject to [paragraph \(2\) of section 1396o\(h\)](#) of this title, reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and

(II) treat such coverage as a third party liability under subsection (a)(25) of this section.

(B) In the case of a parent to which subparagraph (A) applies, a State, notwithstanding [section 1396e](#) of this title but subject to paragraph (1)(C)(ii), may provide for payment of any portion of the annual premium for such family coverage that the parent is required to pay. Any payments made by the State under this subparagraph shall be considered, for purposes of [section 1396b\(a\)](#) of this title, to be payments for medical assistance.

(dd) Electronic transmission of information

If the State agency determining eligibility for medical assistance under this subchapter or child health assistance under subchapter XXI of this chapter verifies an element of eligibility based on information from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act ([44 U.S.C. 3504](#) note). The requirements of [subparagraphs \(A\) and \(B\) of section 1320b-7\(d\)\(2\)](#) of this title may be met through evidence in digital or electronic form.

(ee)(1) For purposes of subsection (a)(46)(B)(ii), the requirements of this subsection with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this subchapter, are, in lieu of requiring the individual to present satisfactory documentary evidence of citizenship or nationality under [section 1396b\(x\)](#) of this title (if the individual is not described in paragraph (2) of that section), as follows:

(A) The State submits the name and social security number of the individual to the Commissioner of Social Security as part of the program established under paragraph (2).

(B) If the State receives notice from the Commissioner of Social Security that the name or social security number, or the declaration of citizenship or nationality, of the individual is inconsistent with information in the records maintained by the Commissioner--

(i) the State makes a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the individual to confirm the accuracy of the name or social security number submitted or declaration of citizenship or nationality and by taking such additional actions as the Secretary, through regulation or other guidance, or the State may identify, and continues to provide the individual with medical assistance while making such effort; and

(ii) in the case such inconsistency is not resolved under clause (i), the State--

(I) notifies the individual of such fact;

(II) provides the individual with a period of 90 days from the date on which the notice required under subclause (I) is received by the individual to either present satisfactory documentary evidence of citizenship or nationality (as defined in [section 1396b\(x\)\(3\)](#) of this title) or resolve the inconsistency with the Commissioner of Social Security (and continues to provide the individual with medical assistance during such 90-day period); and

(III) disenrolls the individual from the State plan under this subchapter within 30 days after the end of such 90-day period if no such documentary evidence is presented or if such inconsistency is not resolved.

(2)(A) Each State electing to satisfy the requirements of this subsection for purposes of section 1396a(a)(46)(B) of this title shall establish a program under which the State submits at least monthly to the Commissioner of Social Security for comparison of the name and social security number, of each individual newly enrolled in the State plan under this subchapter that month who is not described in [section 1396b\(x\)\(2\)](#) of this title and who declares to be a United States citizen or national, with information in records maintained by the Commissioner.

(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of social security--

(i) to provide, through an on-line system or otherwise, for the electronic submission of, and response to, the information

submitted under subparagraph (A) for an individual enrolled in the State plan under this subchapter who declares to be citizen or national on at least a monthly basis; or

(ii) to provide for a determination of the consistency of the information submitted with the information maintained in the records of the Commissioner through such other method as agreed to by the State and the Commissioner and approved by the Secretary, provided that such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in clause (i).

(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social security number to the State under subparagraph (A) and who is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in [section 1396b\(x\)\(3\)](#) of this title) as is provided under [clauses \(i\) and \(ii\) of section 1320b-7\(d\)\(4\)\(A\)](#) of this title to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(3)(A) The State agency implementing the plan approved under this subchapter shall, at such times and in such form as the Secretary may specify, provide information on the percentage each month that the inconsistent submissions bears to the total submissions made for comparison for such month. For purposes of this subparagraph, a name, social security number, or declaration of citizenship or Nationality of an individual shall be treated as inconsistent and included in the determination of such percentage only if--

(i) the information submitted by the individual is not consistent with information in records maintained by the Commissioner of Social Security;

(ii) the inconsistency is not resolved by the State;

(iii) the individual was provided with a reasonable period of time to resolve the inconsistency with the Commissioner of Social Security or provide satisfactory documentation of citizenship status and did not successfully resolve such inconsistency; and

(iv) payment has been made for an item or service furnished to the individual under this subchapter.

(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (a) is greater than 3 percent--

(i) the State shall develop and adopt a corrective plan to review its procedures for verifying the identities of individuals seeking to enroll in the State plan under this subchapter and to identify and implement changes in such procedures to improve their accuracy; and

(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the State plan for the fiscal year for providing medical assistance to individuals who provided inconsistent information as the number of individuals with inconsistent information in excess of 3 percent of such total submitted bears to the total number of individuals with inconsistent information.

(C) The Secretary may waive, in certain limited cases, all or part of the payment under subparagraph (B)(ii) if the State is unable to reach the allowable error rate despite a good faith effort by such State.

(D) Subparagraphs (A) and (B) shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year that provides for the submission on a real-time basis of the information described in such paragraph.

(4) Nothing in this subsection shall affect the rights of any individual under this subchapter to appeal any disenrollment from a State plan.

(ff) Notwithstanding any other requirement of this subchapter or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this subchapter:

(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

[FN1] See Codifications note set out under this section.

[FN2] See References in Text notes set out under this section.

[FN3] So in original. The semicolon probably should be a comma.

[FN4] So in original. Probably should be followed by “and”.

[FN5] So in original. The word “to” probably should not appear.

[FN6] So in original. Probably should be followed by a comma.

[FN7] So in original.

[FN8] So in original. Probably should be [section “1396d\(1\)\(2\)\(B\)”](#).

[FN9] So in original. Probably should be “an”.

[FN10] So in original. The words “this paragraph” probably should be “this subsection”.

[FN11] So in original. Probably should be subsection “(a)(56)”.

§ 1396b. Payment to States

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966--

(1) an amount equal to the Federal medical assistance percentage (as defined in [section 1396d\(b\)](#) of this title, subject to subsections (g) and (j) of this section and [section 1396r-4\(f\)](#) of this title) of the total amount expended during such quarter as medical assistance under the State plan; plus

(2)(A) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in [section 1396r\(e\)\(1\)](#) of this title (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under [section 1396r\(e\)\(7\)](#) of this title; plus

(D) for each calendar quarter during--

(i) fiscal year 1991, an amount equal to 90 percent,

(ii) fiscal year 1992, an amount equal to 85 percent,

(iii) fiscal year 1993, an amount equal to 80 percent, and

(iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment of, retention of, and use of services under this subchapter by, children of families for whom English is not the primary language; plus

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under [section 1396r\(g\)](#) of this title; plus

(3) an amount equal to--

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development,

or installation of such **mechanized claims processing** and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of subchapter XVIII of this chapter, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this chapter,

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed \$150,000), and

(iii) an amount equal to the Federal medical assistance percentage (as defined in [section 1396d\(b\)](#) of this title) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

(C)(i) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization or by an entity which meets the requirements of [section 1320c-1](#) of this title, as determined by the Secretary, under a contract entered into under [section 1396a\(d\)](#) of this title; and

(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under [section 1396u-2\(c\)\(2\)](#) of this title; and

(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of [section 1396r-8\(g\)](#) of this title;

(E) 50 percent of the sums expended with respect to costs incurred during such quarter as are attributable to providing--

(i) services to identify and educate individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease or who are carriers of the sickle cell gene, including education regarding how to identify such individuals; or

(ii) education regarding the risks of stroke and other complications, as well as the prevention of stroke and other complications, in individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease; and

(F)(i) [\[FNI\]](#) 90 percent of the sums expended during the quarter as are attributable to the design, development, or instal-

lation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement [section 1396a\(ee\)](#) of this title (including a system described in paragraph (2)(B) thereof), and

(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies, plus

(F)(i) [FNI](#) 100 percent of so much of the sums expended during such quarter as are attributable to payments to Medicaid providers described in subsection (t)(1) to encourage the adoption and use of certified EHR technology; and

(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in [section 1320b-7\(d\)](#) of this title; plus

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3) of this section, an amount equal to--

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State Medicaid fraud control unit (described in subsection (q) of this section); plus

(7) subject to [section 1396r\(g\)\(3\)\(B\)](#) of this title, an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) Quarterly expenditures beginning after December 31, 1969

(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) of this section for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of subchapter XVIII of this chapter, other than amounts expended under provisions of the plan of such State required by [section 1396a\(a\)\(34\)](#) of this title.

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see [section 1320a-1](#) of this title.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) of this section may not exceed the higher of--

(A) \$125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this subchapter.

(4) Amounts expended by a State for the use of an enrollment broker in marketing medicaid managed care organizations and other managed care entities to eligible individuals under this subchapter shall be considered, for purposes of subsection (a)(7) of this section, to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this subchapter) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this subchapter or subchapter XVIII of this chapter or debarred by any Federal agency, or subject to a civil money penalty under this chapter.

(5) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) of this section for any State shall be decreased in a quarter by the amount of any health care related taxes (described in [section 1396a\(w\)\(3\)\(A\)](#) of this title) that are imposed on a hospital described in subsection (w)(3)(F) of this section in that quarter.

(c) Treatment of educationally-related services

Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) of this section for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act [[20 U.S.C.A. § 1411 et seq.](#)] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act [[20 U.S.C.A. § 1471 et seq.](#)].

(d) Estimates of State entitlement; installments; adjustments to reflect overpayments or underpayments; time for recovery or adjustment; uncollectable or discharged debts; obligated appropriations; disputed claims

(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) of this section for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(B) Expenditures for which payments were made to the State under subsection (a) of this section shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with [section 1396a\(a\)\(25\)](#) of this title.

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.

(D) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

(3)(A) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(B)(i) Subparagraph (A) and paragraph (2)(B) shall not apply to any amount recovered or paid to a State as part of the comprehensive settlement of November 1998 between manufacturers of tobacco products, as defined in [section 5702\(d\) of the Internal Revenue Code of 1986](#) [26 U.S.C.A. § 5702(d)], and State Attorneys General, or as part of any individual State settlement or judgment reached in litigation initiated or pursued by a State against one or more such manufacturers.

(ii) Except as provided in subsection (i)(19), a State may use amounts recovered or paid to the State as part of a comprehensive or individual settlement, or a judgment, described in clause (i) for any expenditures determined appropriate by the State.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under [section 1316\(d\)](#) of this title, and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this subchapter, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(6)(A) Each State (as defined in subsection (w)(7)(D) of this section) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to--

(i) provider-related donations made to the State or units of local government during such fiscal year, and

(ii) health care related taxes collected by the State or such units during such fiscal year.

(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under [section 1396r-4\(c\)](#) of this title during such fiscal year.

(e) Transition costs of closures or conversions permitted

A State plan approved under this subchapter may include, as a cost with respect to hospital services under the plan under this subchapter, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under [section 1395uu](#) of this title.

(f) Limitation on Federal participation in medical assistance

(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 1/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of subchapter IV of this chapter.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of \$100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of \$100 or such other amount, as the case may be.

(2) (A) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, **(B)** notwithstanding [section 1396o](#) of this section at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) of this section will be reduced by amounts paid to the State pursuant to this subparagraph.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of subchapter IV of this chapter shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in [section 1396a\(a\)\(10\)\(A\)\(i\)\(III\)](#), [1396a\(a\)\(10\)\(A\)\(i\)\(IV\)](#), [1396a\(a\)\(10\)\(A\)\(i\)\(V\)](#), [1396a\(a\)\(10\)\(A\)\(i\)\(VI\)](#), [1396a\(a\)\(10\)\(A\)\(i\)\(VII\)](#), [1396a\(a\)\(10\)\(A\)\(ii\)\(IX\)](#), [1396a\(a\)\(10\)\(A\)\(ii\)\(X\)](#), or [1396a\(a\)\(10\)\(A\)\(ii\)\(XIII\)](#), [1396a\(a\)\(10\)\(A\)\(ii\)\(XIV\)](#), or [FN21396a\(a\)\(10\)\(A\)\(ii\)\(XV\)](#), [1396a\(a\)\(10\)\(A\)\(ii\)\(XVI\)](#), [1396a\(a\)\(10\)\(A\)\(ii\)\(XVII\)](#), [1396a\(a\)\(10\)\(A\)\(ii\)\(XVIII\)](#), [1396a\(a\)\(10\)\(A\)\(ii\)\(XIX\)](#), [1396d\(p\)\(1\)](#) of this title or for any individual--

(A) who is receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of

this chapter, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in [section 1396a\(a\)\(10\)\(A\)](#) of this title or who is a PACE program eligible individual enrolled in a PACE program under [section 1396u-4](#) of this title, but only if the income of such individual (as determined under [section 1382a](#) of this title, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by [section 1382\(b\)\(1\)](#) of this title,

at the time of the provision of the medical assistance giving rise to such expenditure.

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in [section 1395mm](#) of this title or which is a qualified health maintenance organization (as defined in [section 300e-9\(d\)](#) of this title)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in **an intermediate care facility for the mentally retarded** for 60 days or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded pursuant to paragraphs (26) and (31) of [section 1396a\(a\)](#) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under [section 1395d](#) of this title.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this subchapter, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect--

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes ef-

fect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally retarded under paragraphs (26) and (31) of [section 1396a\(a\)](#) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter--

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to $33 \frac{1}{3}$ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under [section 1396a\(a\)\(44\)](#) of this title shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least--

(i) 60 days after the date of the initial certification,

(ii) 180 days after the date of the initial certification,

- (iii) 12 months after the date of the initial certification,
- (iv) 18 months after the date of the initial certification,
- (v) 24 months after the date of the initial certification, and
- (vi) every 12 months thereafter.

(C) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(h) Repealed. Pub.L. 100-203, Title IV, § 4211(g)(1), Dec. 22, 1987, 101 Stat. 1330-205

(i) Payment for organ transplants; item or service furnished by excluded individual, entity, or physician; other restrictions

Payment under the preceding provisions of this section shall not be made--

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that--

(A) similarly situated individuals are treated alike; and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; or

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished--

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under subchapter V, XVIII, or XX of this chapter or under this subchapter pursuant to [section 1320a-7](#), [1320a-7a](#), [1320c-5](#), or [1395u\(j\)\(2\)](#) of this title, or

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under subchapter V, XVIII, or XX of this chapter or under this subchapter pursuant to [section 1320a-7](#), [1320a-7a](#), [1320c-5](#), or [1395u\(j\)\(2\)](#) of this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan (other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs) to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirements imposed by [section 1395x\(k\)](#) of this title for purposes of subchapter XVIII of this chapter; and if such hospital has in effect such a utilization review plan for purposes of subchapter

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XVIII of this chapter, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this subchapter; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under [section 1395x\(k\)](#) of this title; or

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of subchapter XVIII of this chapter because of [section 1395y\(c\)](#) of this title; or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under [section 1395l\(h\)](#) of this title for such tests performed for an individual enrolled under part B of subchapter XVIII of this chapter; or

(8) with respect to any amount expended for medical assistance (A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under [section 1396r\(h\)](#) of this title or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this subchapter or subchapter XI of this chapter or for legal expenses in defense of an exclusion or civil money penalty under this subchapter or subchapter XI of this chapter if there is no reasonable legal ground for the provider's case; or

(9) Repealed. [Pub.L. 104-193, Title I, §§ 114\(d\)\(2\)](#), 116, Aug. 22, 1996, 110 Stat. 2180

(10)(A) with respect to covered outpatient drugs unless there is a rebate agreement in effect under [section 1396r-8](#) of this title with respect to such drugs or unless [section 1396r-8\(a\)\(3\)](#) of this title applies,

(B) with respect to any amount expended for an innovator multiple source drug (as defined in [section 1396r-8\(k\)](#) of this title) dispensed on or after July 1, 1991, if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug;

(C) with respect to covered outpatient drugs described in [section 1396r-8\(a\)\(7\)](#) of this title, unless information respecting utilization data and coding on such drugs that is required to be submitted under such section is submitted in accordance with such section, and

(D) with respect to any amount expended for reimbursement to a pharmacy under this title for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this title (other than with respect to a reasonable restocking fee for such drug); or

(11) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under [section 1396a\(x\)](#) of this title, unless the claim for the services includes the unique physician identifier provided under such system; or

(12) Repealed. [Pub.L. 105-33, Title IV, § 4742\(a\)](#), Aug. 5, 1997, 111 Stat. 523

(13) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action; or

(14) with respect to any amount expended on administrative costs to carry out the program under [section 1396s](#) of this title; or

(15) with respect to any amount expended for a single-antigen vaccine and its administration in any case in which the administration of a combined-antigen vaccine was medically appropriate (as determined by the Secretary); or

(16) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 [[42 U.S.C.A. § 14401 et seq.](#)]; or

(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this subchapter; or

(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under [paragraph \(7\) of section 1395x\(o\)](#) of this title and in an amount that is not less than \$50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section; or

(19) with respect to any amount expended on administrative costs to initiate or pursue litigation described in subsection (d)(3)(B);

(20) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1396a(a)(10)(A)(ii) of this title for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before the date of the enactment of this paragraph;

(21) with respect to amounts expended for covered outpatient drugs described in [section 1396r-8\(d\)\(2\)\(K\)](#) of this title (relating to drugs when used for treatment of sexual or erectile dysfunction);

(22) with respect to amounts expended for medical assistance for an individual who declares under [section 1320b-7\(d\)\(1\)\(A\)](#) of this title to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this subchapter, unless the requirement of [section 1396a\(a\)\(46\)\(B\)](#) of this title is met;

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in [section 1396r-8\(k\)\(2\)](#) of this title) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad; or

(24) If a State is required to implement an asset verification program under [section 1396w](#) of this title and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless--

(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; and

(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this subchapter that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in [section 1396u-2\(a\)\(1\)\(B\)](#) of this title) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

(j) Adjustment of amount

Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) of this section for any State for any quarter shall be adjusted in accordance with [section 1396m](#) of this title.

(k) Technical assistance to States

The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any medicaid managed care organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this subchapter.

(l) Repealed. Pub.L. 94-552, § 1, Oct. 18, 1976, 90 Stat. 2540

(m) “Medicaid managed care organization” defined; duties and functions of Secretary; payments to States; reporting requirements; remedies

(1)(A) The term “medicaid managed care organization” means a health maintenance organization, an eligible organization with a contract under [section 1395mm](#) of this title or a Medicare+Choice organization with a contract under part C of subchapter XVIII of this chapter, a provider sponsored organization, or any other public or private organization, which meets the requirement of [section 1396a\(w\)](#) of this title and--

(i) makes services it provides to individuals eligible for benefits under this subchapter accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this subchapter are in no case held liable for debts of the organization in case of the organization's insolvency.

An organization that is a qualified health maintenance organization (as defined in [section 300e-9\(d\)](#) of this title) is deemed to meet the requirements of clauses (i) and (ii).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a medicaid managed care organization within the meaning of subparagraph (A), shall be integrated with the administration of [section 300e-11\(a\)](#) and [\(b\)](#) of this title.

(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

(ii) Clause (i) shall not apply to an organization if--

(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians' services;

(II) the organization is a public entity;

(III) the solvency of the organization is guaranteed by the State; or

(IV) the organization is (or is controlled by) one or more Federally-qualified [\[FN3\]](#) health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term "control" means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in [paragraph \(2\), \(3\), \(4\), \(5\), or \(7\) of section 1396d\(a\)](#) of this title or for the provision of any three or more of the services described in such paragraphs unless--

(i) the Secretary has determined that the entity is a medicaid managed care organization as defined in paragraph (1);

(ii) Repealed. [Pub.L. 105-33, Title IV, § 4703\(a\)](#), Aug. 5, 1997, 111 Stat. 495

(iii) such services are provided for the benefit of individuals eligible for benefits under this subchapter in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of \$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this subchapter and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment in accordance with [section 1396u-2\(a\)\(4\)](#) of this title, and (II) provides for notification in accordance with such section [\[FN4\]](#) of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or

condition, either the entity or the State provides for reimbursement with respect to those services, [\[FN5\]](#)

(viii) such contract provides for disclosure of information in accordance with [section 1320a-3](#) of this title and paragraph (4) of this subsection;

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified [\[FN3\]](#) health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic;

(x) any physician incentive plan that it operates meets the requirements described in [section 1395mm\(i\)\(8\)](#) of this title;

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients; and

(xii) such contract, and the entity complies with the applicable requirements of [section 1396u-2](#) of this title.

(B) Subparagraph (A) [\[FN6\]](#) except with respect to clause (ix) of subparagraph (A), does not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services provided by an entity which--

(i)(I) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under [section 254b\(d\)\(1\)\(A\)](#) or [254c\(d\)\(1\)](#) of this title, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in [paragraphs \(1\), \(2\), \(3\), \(4\)\(C\), and \(5\) of section 1396d\(a\)](#) of this title and, to the extent required by [section 1396a\(a\)\(10\)\(D\)](#) of this title to be provided under a State plan for medical assistance, the services and benefits described in [paragraph \(7\) of section 1396d\(a\)](#) of this title; or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)--

(I) which received in the fiscal year ending June 30, 1976, at least \$100,000 (by grant, subgrant, or subcontract) under Subtitle IV of Title 40, and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this subchapter on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this subchapter on a prepaid risk basis prior to 1970.

(C) to (E) Repealed. [Pub.L. 105-33, Title IV, § 4703\(b\)\(1\)\(A\)](#), Aug. 5, 1997, 111 Stat. 495

(F) Repealed. [Pub.L. 105-33, Title IV, § 4701\(d\)\(2\)\(B\)](#), Aug. 5, 1997, 111 Stat. 494

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least \$100,000

under [section 254b\(d\)\(1\)\(A\)](#) or [254c\(d\)\(1\)](#) of this title or is receiving (and has received during the previous two years) at least \$100,000 (by grant, subgrant, or subcontract) under Subtitle IV of Title 40, clause (i) of subparagraph (A) shall not apply.

(H) In the case of an individual who--

(i) in a month is eligible for benefits under this subchapter and enrolled with a medicaid managed care organization with a contract under this paragraph or with a primary care case manager with a contract described in [section 1396d\(t\)\(3\)](#) of this title,

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the organization described in clause (i) if the organization continues to have a contract under this paragraph with the State or with the manager described in such clause if the manager continues to have a contract described in [section 1396d\(t\)\(3\)](#) of this title with the State.

(3) Repealed. [Pub.L. 101-508, Title IV, § 4732\(d\)\(2\)](#), Nov. 5, 1990, 104 Stat. 1388-196

(4)(A) Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in [section 300e-9\(d\)](#) of this title) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in [section 300e-17\(b\)](#) of this title), including the following transactions:

(i) Any sale or exchange, or leasing of any property between the organization and such a party.

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5)(A) If the Secretary determines that an entity with a contract under this subsection--

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this subchapter;

(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to reenroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished--

(I) to the Secretary or the State under this subsection, or

(II) to an individual or to any other entity under this subsection, [\[FNS\]](#) or

(v) fails to comply with the requirements of [section 1395mm\(i\)\(8\)](#) of this title,

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are--

(i) civil money penalties of not more than \$25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than \$100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), \$15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of [section 1320a-7a](#) of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(6)(A) For purposes of this subsection and [section 1396a\(e\)\(2\)\(A\)](#) of this title, in the case of the State of New Jersey, the term "contract" shall be deemed to include an undertaking by the State agency, in the State plan under this subchapter, to operate a program meeting all requirements of this subsection.

(B) The undertaking described in subparagraph (A) must provide--

(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this subchapter;

(ii) for separate accounting for the funds used to operate such program; and

(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this subchapter for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population.

(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual re-approval) by the Secretary in the same manner as a contract under this subsection.

(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under [section 1396n\(b\)](#) of this title.

(n) Repealed. Pub.L. 100-93, § 8(h)(1), Aug. 18, 1987, 101 Stat. 694

(o) Restrictions on authorized payments to States

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this subchapter to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in [section 1167\(1\) of Title 29](#)), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p) Assignment of rights of payment; incentive payments for enforcement and collection

(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under [section 1396k](#) of this title, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) “State medicaid fraud control unit” defined

For the purposes of this section, the term “State medicaid fraud control unit” means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this subchapter to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this subchapter.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this subchapter.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all appli-

cable State laws regarding any and all aspects of fraud in connection with (A) any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this subchapter; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in [section 1320a-7b\(f\)\(1\)](#) of this title), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this subchapter.

(4)(A) The entity has--

(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this subchapter;

(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

(B) For purposes of this paragraph, the term “board and care facility” means a residential setting which receives payment (regardless of whether such payment is made under the State plan under this title) from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan or under any Federal health care program (as so defined) to health care facilities and that are discovered by the entity in carrying out its activities. All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this subchapter) that was subject to the activity that was the basis for the collection.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r) Mechanized claims processing and information retrieval systems; operational, etc., requirements

(1) In order to receive payments under subsection (a) of this section for use of automated data systems in administration of the State plan under this subchapter, a State must, in addition to meeting the requirements of paragraph (3), have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found--

(A) are adequate to provide efficient, economical, and effective administration of such State plan;

(B) are compatible with the claims processing and information retrieval systems used in the administration of subchapter XVIII of this chapter, and for this purpose--

(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this subchapter or subchapter XVIII of this chapter;

(ii) provide liaison between States and carriers and intermediaries with agreements under subchapter XVIII of this chapter to facilitate timely exchange of appropriate data; and

(iii) provide for exchange of data between the States and the Secretary with respect to persons sanctioned under this subchapter or subchapter XVIII of this chapter;

(C) are capable of providing accurate and timely data;

(D) are complying with the applicable provisions of part C of subchapter XI of this chapter;

(E) are designed to receive provider claims in standard formats to the extent specified by the Secretary; and

(F) effective for claims filed on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary).

(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:

(A) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(B) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

(C) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary.

(3) In order to meet the requirements of this paragraph, a State must have in operation an eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS) facilitated by the Secretary (or any successor system), including matching with medical assistance programs operated by other States.

(s) Limitations on certain physician referrals

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under this section for expenditures for medical assistance under the State plan consisting of a designated health service (as defined in [subsection \(h\)\(6\) of section 1395nn](#) of this title) furnished to an individual on the basis of a referral that would result in the denial of payment for the service under subchapter XVIII of this chapter if such subchapter provided for coverage of such service to the same extent and under the same terms and conditions as under the State plan, and subsections (f) and (g)(5) of such section shall apply to a provider of such a designated health service for which payment may be made under this subchapter in the same manner as such subsections apply to a provider of such a service for which payment may be made under such subchapter.

(t)(1) For purposes of subsection (a)(3)(F), the payments described in this paragraph to encourage the adoption and use of certified EHR technology are payments made by the State in accordance with this subsection--

(A) to Medicaid providers described in paragraph (2)(A) not in excess of 85 percent of net average allowable costs (as defined in paragraph (3)(E)) for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) with respect to such providers; and

(B) to Medicaid providers described in paragraph (2)(B) not in excess of the maximum amount permitted under paragraph (5) for the provider involved.

(2) In this subsection and subsection (a)(3)(F), the term “Medicaid provider” means--

(A) an eligible professional (as defined in paragraph (3)(B))--

(i) who is not hospital-based and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter;

(ii) who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter; and

(iii) who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)); and

(B)(i) a children's hospital, or

(ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under [sections 1395w-4\(o\)](#) and [1395w-23\(l\)](#) of this title with respect to the eligible professional has been waived in a manner specified by the Secretary. For purposes of calculating patient volume under subparagraph (A)(iii), insofar as it is related to uncompensated care, the Secretary may require the adjustment of such uncompensated care data so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care. In applying subparagraphs (A) and (B)(ii), the methodology established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under subsection (m) or [section 1396u-2](#) of this title).

(3) In this subsection and subsection (a)(3)(F):

(A) The term “certified EHR technology” means a qualified electronic health record (as defined in 300jj(13) of this title) that is certified pursuant to [section 300jj-11\(c\)\(5\)](#) of this title as meeting standards adopted under [section 300jj-14](#) of this title that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(B) The term “eligible professional” means a--

(i) physician;

(ii) dentist;

(iii) certified nurse mid-wife;

(iv) nurse practitioner; and

(v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

(C) The term “average allowable costs” means, with respect to certified EHR technology of medicaid providers described in paragraph (2)(A) for--

(i) the first year of payment with respect to such a provider, the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology) for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C); and

(ii) a subsequent year of payment with respect to such a provider, the average costs not described in clause (i) relating to the operation, maintenance, and use of such technology for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C).

(D) The term “hospital-based” means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual's professional services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(E) The term “net average allowable costs” means, with respect to a Medicaid provider described in paragraph (2)(A), average allowable costs reduced by any payment that is made to such Medicaid provider from any other source (other than under this subsection or by a State or local government) that is directly attributable to payment for certified EHR technology or support services described in subparagraph (C).

(F) The term “needy individual” means, with respect to a medicaid provider, an individual--

(i) who is receiving assistance under this subchapter;

(ii) who is receiving assistance under subchapter XXI of this chapter;

(iii) who is furnished uncompensated care by the provider; or

(iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay.

(4)(A) With respect to a Medicaid provider described in paragraph (2)(A), subject to subparagraph (B), in no case shall--

(i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed \$25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C));

(ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed \$10,000; and

(iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years.

(B) In the case of Medicaid provider described in paragraph (2)(A)(ii), the dollar amounts specified in subparagraph (A) shall be $\frac{2}{3}$ of the dollar amounts otherwise specified.

(C) For the purposes of determining average allowable costs under this subsection, the Secretary shall study the average costs to Medicaid providers described in paragraph (2)(A) of purchase and initial implementation and upgrade of certified EHR technology described in paragraph (3)(C)(i) and the average costs to such providers of operations, maintenance, and use of such technology described in paragraph (3)(C)(ii). In determining such costs for such providers, the Secretary may utilize studies of such amounts submitted by States.

(5)(A) In no case shall the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) exceed--

(i) in the aggregate the product of--

(I) the overall hospital EHR amount for the provider computed under subparagraph (B); and

(II) the Medicaid share for such provider computed under subparagraph (C);

(ii) in any year 50 percent of the product described in clause (i); and

(iii) in any 2-year period 90 percent of such product.

(B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a Medicaid provider, is the sum of the applicable amounts specified in [section 1395ww\(n\)\(2\)\(A\)](#) of this title for such provider for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall establish, in consultation with the State, the overall hospital EHR amount for each such Medicaid provider eligible for payments under paragraph (1)(B). For purposes of this subparagraph in computing the amounts under [section 1395ww\(n\)\(2\)\(C\)](#) of this title for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year.

(C) The Medicaid share computed under this subparagraph, for a Medicaid provider for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under [section 1395ww\(n\)\(2\)\(D\)](#) of this title for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this subchapter and who are not described in [section 1395ww\(n\)\(2\)\(D\)\(i\)](#) of this title. In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under subsection (m) or [section 1396u-2](#) of this title).

(D) In no case may the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) be paid--

(i) for any year beginning after 2016 unless the provider has been provided payment under paragraph (1)(B) for the previous year; and

(ii) over a period of more than 6 years of payment.

(6) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met:

(A)(i) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to payments to a Medicaid provider are paid, subject to clause (ii), directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

(ii) Amounts described in clause (i) may also be paid to an entity promoting the adoption of certified EHR technology, as designated by the State, if participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

(B) A Medicaid provider described in paragraph (2)(A) is responsible for payment of the remaining 15 percent of the net average allowable cost.

(C)(i) Subject to clause (ii), with respect to payments to a Medicaid provider--

(I) for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and

(II) for a year of payment, other than the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied under [section 1395w-4\(o\)](#) or [1395ww\(n\)](#) of this title.

(ii) In the case of a Medicaid provider who has completed adopting, implementing, or upgrading such technology prior to the first year of payment to the Medicaid provider under this subsection, clause (i)(I) shall not apply and clause (i)(II) shall apply to each year of payment to the Medicaid provider under this subsection, including the first year of payment.

(D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.

For purposes of subparagraph (B), a Medicaid provider described in paragraph (2)(A) may accept payments for the costs described in such subparagraph from a State or local government. For purposes of subparagraph (C), in establishing the means described in such subparagraph, which may include clinical quality reporting to the State, the State shall ensure that populations with unique needs, such as children, are appropriately addressed.

(7) With respect to Medicaid providers described in paragraph (2)(A), the Secretary shall ensure coordination of payment with respect to such providers under [sections 1395w-4\(o\)](#) and [1395w-23\(l\)](#) of this title and under this subsection to assure no duplication of funding. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. For such pur-

poses, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify.

(8) In carrying out paragraph (6)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this subchapter and subchapter XVIII of this chapter. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under subchapter XVIII of this chapter to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.

(9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State--

(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this subchapter, subject to applicable laws and regulations governing such exchange.

(10) The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments described in paragraph (1), including steps taken to carry out paragraph (7). Such reports shall also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the provisions of this subsection and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.

(u) Limitation of Federal financial participation in erroneous medical assistance expenditures

(1)(A) Notwithstanding subsection (a)(1) of this section, if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this subchapter exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

(C) In estimating the amount to be paid to a State under subsection (d) of this section, the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1) of this section, for purposes of payment to the State under subsection (d)(3) of this section, in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2) of this section).

(D)(i) For purposes of this subsection, the term "erroneous excess payments for medical assistance" means the total of--

(I) payments under the State plan with respect to ineligible individuals and families, and

(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under [section 1396k\(a\)\(1\)\(C\)](#) or [602\(a\)\(26\)\(C\)](#) of this title or with respect to payments made in violation of [section 1396e](#) of this title.

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in [section 1396r-1\(b\)\(1\)](#) of this title) or for items and services described in [subsection \(a\) of section 1396r-1a](#) of this title provided to a child during a presumptive eligibility period under such section, or for medical assistance provided to an individual described in [subsection \(a\) of section 1396r-1b](#) of this title during a presumptive eligibility period under such section.

(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance--

(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to [section 1383c](#) of this title and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

(ii) payments made as the result of a technical error.

(2) The State agency administering the plan approved under this subchapter shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this subchapter for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determina-

tion.

(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

(v) Medical assistance to aliens not lawfully admitted for permanent residence

(1) Notwithstanding the preceding provisions of this section, except as provided in paragraphs (2) and (4), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if--

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this subchapter (other than the requirement of the receipt of aid or assistance under subchapter IV of this chapter, supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment), and

(C) such care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this subchapter, notwithstanding [sections 1611\(a\), 1612\(b\), 1613, and 1631 of Title 8](#), to children and pregnant women who are lawfully residing in the United States (including battered individuals described in [section 1641\(c\) of Title 8](#)) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

(i) Pregnant women

Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

(ii) Children

Individuals under 21 years of age, including optional targeted low-income children described in [section 1396d\(u\)\(2\)\(B\)](#) of this title.

(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance

to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

(C) As part of the State's ongoing eligibility redetermination requirements and procedures for an individual provided medical assistance as a result of an election by the State under subparagraph (A), a State shall verify that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States.

(w) Prohibition on use of voluntary contributions, and limitation on use of provider-specific taxes to obtain Federal financial participation under medicaid

(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) of this section for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year--

(i) from provider-related donations (as defined in paragraph (2)(A)), other than--

(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

(II) donations described in paragraph (2)(C);

(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) of this section for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this subchapter during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a) of this section.

(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation,

or other documentary evidence in existence on that date.

(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(iii) In this subparagraph and subparagraph (E), the term “impermissible tax” means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

(F) In this paragraph in the case of a State--

(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

(2)(A) In this subsection (except as provided in paragraph (6)), the term “provider-related donation” means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by-

(i) a health care provider (as defined in paragraph (7)(B)),

(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a) of this section.

(B) For purposes of paragraph (1)(A)(i)(I), the term “bona fide provider-related donation” means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this subchapter to

that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this subchapter and to provide outreach services to eligible or potentially eligible individuals.

(3)(A) In this subsection (except as provided in paragraph (6)), the term “health care related tax” means a tax (as defined in paragraph (7)(F)) that--

(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

(B) In this subsection, the term “broad-based health care related tax” means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D), (E), and (F)--

(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

(ii) is imposed uniformly (in accordance with subparagraph (C)).

(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if--

(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly--

(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this subchapter or subchapter XVIII of this chapter, or

(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this subchapter or subchapter XVIII of this chapter.

(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that--

(I) the net impact of the tax and associated expenditures under this subchapter as proposed by the State is generally redistributive in nature, and

(II) the amount of the tax is not directly correlated to payments under this subchapter for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in [section 501\(c\)\(3\) of the Internal Revenue Code of 1986](#) and exempt from taxation under [section 501\(a\) of Title 26](#) and that does not accept payment under the State plan under this subchapter or under subchapter XVIII of this chapter.

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this subchapter) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

(B) All or any portion of the payment made under this subchapter to the taxpayer varies based only upon the amount of the total tax paid.

(C)(i) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

(ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under [paragraph \(3\)\(i\) of section 433.68\(f\) of title 42, Code of Federal Regulations](#), as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, “5.5 percent” shall be substituted for “6 percent” each place it appears.

The provisions of this paragraph shall not prevent use of the tax to reimbursed health care providers in a class for expenditures under this subchapter nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

(B)(i) In subparagraph (A), the term “State base percentage” means, with respect to a State, an amount (expressed as a percentage) equal to--

(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of December 12, 1991.

(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider, except as provided in [section 1396a\(a\)\(2\)](#) of this title, unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

(7) For purposes of this subsection:

(A) Each of the following shall be considered a separate class of health care items and services:

(i) Inpatient hospital services.

(ii) Outpatient hospital services.

(iii) **Nursing facility services** (other than services of intermediate care facilities for the mentally retarded).

(iv) Services of intermediate care facilities for the mentally retarded.

(v) Physicians' services.

(vi) Home health care services.

(vii) Outpatient prescription drugs.

(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).

(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

(B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.

(C) An entity is considered to be "related" to a health care provider if the entity--

(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

(ii) is a person with an ownership or control interest (as defined in [section 1320a-3\(a\)\(3\)](#) of this title) in the provider;

(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

(iv) has a similar, close relationship (as defined in regulations) to the provider.

(D) The term "State" means only the 50 States and the District of Columbia but does not include any State whose entire program under this subchapter is operated under a waiver granted under [section 1315](#) of this title.

(E) The "State fiscal year" means, with respect to a specified year, a State fiscal year ending in that specified year.

(F) The term "tax" includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

(G) The term "unit of local government" means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.

(x)(1) For purposes of [section 1396a\(a\)\(46\)\(B\)\(i\)](#) of this title, the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

(2) The requirement of paragraph (1) shall not apply to an individual declaring to be a citizen or national of the United States who is eligible for medical assistance under this subchapter--

(A) and is entitled to or enrolled for benefits under any part of subchapter XVIII of this chapter;

(B) and is receiving--

(i) disability insurance benefits under [section 423](#) of this title or monthly insurance benefits under [section 402](#) of this title based on such individual's disability (as defined in [section 423\(d\)](#) of this title); or

(ii) supplemental security income benefits under subchapter XVI of this title;

(C) and with respect to whom--

(i) child welfare services are made available under part B of subchapter IV of this chapter on the basis of being a child in foster care; or

(ii) adoption or foster care assistance is made available under part E of subchapter IV of this chapter;

(D) pursuant to the application of [section 1396a\(e\)\(4\)](#) of this title (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or

(E) on such basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality has been previously presented.

(3)(A) For purposes of this subsection, the term "satisfactory documentary evidence of citizenship or Nationality" means--

(i) any document described in subparagraph (B); or

(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

(B) The following are documents described in this subparagraph:

(i) A United States passport.

(ii) Form N-550 or N-570 (Certificate of Naturalization).

(iii) Form N-560 or N-561 (Certificate of United States Citizenship).

(iv) A valid State-issued driver's license or other identity document described in [section 1324a\(b\)\(1\)\(D\) of Title 8](#), but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license

or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.

(v)(I) Except as provided in subclause (II), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

(II) With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.

(vi) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

(C) The following are documents described in this subparagraph:

(i) A certificate of birth in the United States.

(ii) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).

(iii) Form I-197 (United States Citizen Identification Card).

(iv) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).

(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.

(D) The following are documents described in this subparagraph:

(i) Any identity document described in [section 1324a\(b\)\(1\)\(D\) of Title 8](#).

(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

(E) A reference in this paragraph to a form includes a reference to any successor form.

(4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under [section 1396a\(a\)\(46\)\(B\)\(i\)](#) of this title, the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under [clauses \(i\) and \(ii\) of section 1320b-7\(d\)\(4\)\(A\)](#) of this title to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(5) Nothing in [subparagraph \(A\)](#) or [\(B\) of section 1396a\(a\)\(46\)](#) of this title, the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of [section 1396a\(e\)\(4\)](#) of this title that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be

deemed eligible for medical assistance during the first year of such child's life.

(y) Payments for establishment of alternate non-emergency services providers

(1) Payments

In addition to the payments otherwise provided under subsection (a) of this section, subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in [section 1396o-1\(e\)\(5\)\(B\)](#) of this title), or networks of such providers.

(2) Limitation

The total amount of payments under this subsection shall not exceed \$50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(3) Preference

In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that--

(A) serve rural or underserved areas where beneficiaries under this subchapter may not have regular access to providers of primary care services; or

(B) are in partnership with local community hospitals.

(4) Form and manner of payment

Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under subsec. (a) of this section.

(z) Medicaid transformation payments

(1) In general

In addition to the payments provided under subsection (a) of this section, subject to paragraph (4), the Secretary shall provide for payments to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this subchapter.

(2) Permissible uses of funds

The following are examples of innovative methods for which funds provided under this subsection may be used:

(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

(B) Methods for improving rates of collection from estates of amounts owed under this subchapter.

(C) Methods for reducing waste, fraud, and abuse under the program under this subchapter, such as reducing improper payment rates as measured by annual payment error rate measurement (PERM) project rates.

(D) Implementation of a medication risk management program as part of a drug use review program under [section 1396r-8\(g\)](#) of this title.

(E) Methods in reducing, in clinically appropriate ways, expenditures under this subchapter for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs.

(F) Methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.

(3) Application; terms and conditions

(A) In general

No payments shall be made to a State under this subsection unless the State applies to the Secretary for such payments in a form, manner, and time specified by the Secretary.

(B) Terms and conditions

Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

(C) Annual report

Payment to a State under this subsection is conditioned on the State submitting to the Secretary an annual report on the programs supported by such payment. Such report shall include information on--

- (i) the specific uses of such payment;
- (ii) an assessment of quality improvements and clinical outcomes under such programs; and
- (iii) estimates of cost savings resulting from such programs.

(4) Funding

(A) Limitation on funds

The total amount of payments under this subsection shall be equal to, and shall not exceed--

- (i) \$75,000,000 for fiscal year 2007; and
- (ii) \$75,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(B) Allocation of funds

The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. Such method shall provide that not less than 25 percent of such funds shall be allocated among States the population of which (as determined according to data collected by the United States Census Bureau) as of July 1, 2004, was more than 105 percent of the population of the respective State (as so determined) as of April 1, 2000.

(C) Form and manner of payment

Payment to a State under this subsection shall be made in the same manner as other payments under subsection (a) of this section. There is no requirement for State matching funds to receive payments under this subsection.

(5) Medication risk management program

(A) In general

For purposes of this subsection, the term “medication risk management program” means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

(B) Elements

Such program may include the following elements:

- (i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.
- (ii) On an ongoing basis provide outlier physicians--
 - (I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;
 - (II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician's care; and
 - (III) applicable best practice guidelines and empirical references.
- (iii) Monitor outlier physician's prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

(C) Targeted beneficiaries

For purposes of this paragraph, the term “targeted beneficiaries” means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.

[FN1] So in original. Two subpars. (F) have been enacted.

[FN2] So in original. The word “or” probably should precede “1396d(p)(1)”.

[FN3] So in original. Probably should not be capitalized.

[FN4] So in original. The phrase “in accordance with such section” probably should appear before the semicolon at the end of subcl. (II).

[FN5] So in original. The comma probably should be a semicolon.

[FN6] So in original. Probably should be followed by a comma.

§ 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds--

- (1) that the plan has been so changed that it no longer complies with the provisions of [section 1396a](#) of this title; or
- (2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

§ 1396d. Definitions

For purposes of this subchapter--

(a) Medical assistance

The term “medical assistance” means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in [section 1396a\(a\)\(10\)\(A\)](#) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are--

- (i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,
- (ii) relatives specified in [section 606\(b\)](#)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in [section 1382c](#) of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter,

(viii) pregnant women,

(ix) individuals provided extended benefits under [section 1396r-6](#) of this title,

(x) individuals described in [section 1396a\(u\)\(1\)](#) of this title,

(xi) individuals described in [section 1396a\(z\)\(1\)](#) of this title,

(xii) employed individuals with a medically improved disability (as defined in subsection (v)), or

(xiii) individuals described in [section 1396a\(aa\)\[FN1\]](#) of this title,

but whose income and resources are insufficient to meet all of such cost--

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2) (A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1) of this section) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4) (A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) (A) physicians' services furnished by a physician (as defined in [section 1395x\(r\)\(1\)](#) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in [section 1395x\(r\)\(2\)](#) of this title) to the extent such services may be performed under State law ei-

ther by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in [section 1395x\(r\)\(1\)](#) of this title);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with [section 1396a\(a\)\(31\)](#) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in [section 1395x\(gg\)](#) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o) of this section);

(19) case-management services (as defined in [section 1396n\(g\)\(2\)](#) of this title) and TB-related services described in [section 1396a\(z\)\(2\)\(F\)](#) of this title;

(20) respiratory care services (as defined in [section 1396a\(e\)\(9\)\(C\)](#) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the

Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in [section 1396t](#) of this title) for functionally disabled elderly individuals; and

(23) community supported living arrangements services (to the extent allowed and as defined in [section 1396u](#) of this title);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t) of this section);

(26) services furnished under a PACE program under [section 1396u-4](#) of this title to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x) of this section, primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease; and

(28) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary,

except as otherwise provided in paragraph (16), **such term does not include--**

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI of this chapter), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII of this chapter for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapters I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in [section 1396a\(a\)\(10\)\(A\)](#) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to [section 1396u-3\(d\)](#) of this title, the term “Federal medical assistance percentage” for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum, (3) for purposes of this subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in [section 1397ee\(b\)](#) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of [section 1396a\(a\)\(10\)\(A\)\(ii\)\(XVIII\)](#) of this title. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of [section 1301\(a\)\(8\)\(B\)](#) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in [section 1603 of Title 25](#)). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures (other than expenditures under [section 1396r-4](#) of this title) described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under [section 1397dd](#) of this title, the Federal medical assistance percentage is equal to the enhanced FMAP described in [section 1397ee\(b\)](#) of this title.

(c) Nursing facility

For definition of the term “nursing facility”, see [section 1396r\(a\)](#) of this title.

(d) Intermediate care facility for mentally retarded

The term “intermediate care facility for the mentally retarded” means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if--

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this subchapter is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this subchapter, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this subchapter.

(e) Physicians' services

In the case of any State the State plan of which (as approved under this subchapter)--

(1) does not provide for the payment of services (other than services covered under [section 1396a\(a\)\(12\)](#) of this title) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term “physicians' services” (as used in subsection (a)(5) of this section) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term “physicians' services”, as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

(f) Nursing facility services

For purposes of this subchapter, the term “nursing facility services” means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) Chiropractors' services

If the State plan includes provision of chiropractors' services, such services include only--

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under [section 1395x\(r\)\(5\)](#) of this title; and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h) Inpatient psychiatric hospital services for individuals under age 21

(1) For purposes of paragraph (16) of subsection (a) of this section, the term “inpatient psychiatric hospital services for individuals under age 21” includes only--

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in [section 1395x\(f\)](#) of this title or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an out-

patient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) Institution for mental diseases

The term “institution for mental diseases” means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) State supplementary payment

The term “State supplementary payment” means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under subchapter XVI of this chapter or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under subchapter XVI of this chapter, or would but for his income be payable under that subchapter.

(k) Supplemental security income benefits

Increased supplemental security income benefits payable pursuant to [section 211 of Public Law 93-66](#) shall not be considered supplemental security income benefits payable under subchapter XVI of this chapter.

(l) Rural health clinics

(1) The terms “rural health clinic services” and “rural health clinic” have the meanings given such terms in [section 1395x\(aa\)](#) of this title, except that (A) clause (ii) of [section 1395x\(aa\)\(2\)](#) of this title shall not apply to such terms, and (B) the physician arrangement required under [section 1395x\(aa\)\(2\)\(B\)](#) of this title shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term “Federally-qualified health center services” means services of the type described in [subparagraphs \(A\) through \(C\) of section 1395x\(aa\)\(1\)](#) of this title when furnished to an individual as an [\[FN2\]](#) patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in [section 1395x\(aa\)\(2\)\(B\)](#) of this title is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term “Federally-qualified health center” means an entity which--

(i) is receiving a grant under [section 254b](#) of this title,

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under [section 254b](#) of this title,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of subchapter XVIII of this chapter, as a comprehensive Federally funded health center as of January 1, 1990;

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act ([Public Law 93-638](#)) [[25 U.S.C.A. § 450f et seq.](#)] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [[25 U.S.C.A. § 1651 et seq.](#)] for the provision of primary health services. In applying clause (ii), [\[FN3\]](#) the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

(m) Qualified family member

(1) Subject to paragraph (2), the term “qualified family member” means an individual (other than a qualified pregnant woman or child, as defined in subsection (n) of this section) who is a member of a family that would be receiving aid under the State plan under part A of subchapter IV of this chapter pursuant to [section 607](#) of this title if the State had not exercised the option under [section 607\(b\)\(2\)\(B\)\(i\)](#) of this title.

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) Qualified pregnant woman or child

The term “qualified pregnant woman or child” means--

(1) a pregnant woman who--

(A) would be eligible for aid to families with dependent children under part A of subchapter IV of this chapter (or would be eligible for such aid if coverage under the State plan under part A of subchapter IV of this chapter included aid to families with dependent children of unemployed parents pursuant to [section 607](#) of this title) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of subchapter IV of this chapter pursuant to [section 607](#) of this title if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of subchapter IV of this chapter; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of subchapter IV of this chapter.

(o) Optional hospice benefits

(1)(A) Subject to subparagraph (B), the term “hospice care” means the care described in [section 1395x\(dd\)\(1\)](#) of this title furnished by a hospice program (as defined in [section 1395x\(dd\)\(2\)](#) of this title) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in [section 1395d\(d\)\(2\)\(A\)](#) of this title and for which payment may otherwise be made under subchapter XVIII of this chapter and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this subchapter, with respect to the definition of hospice program under [section 1395x\(dd\)\(2\)](#) of this title, the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(2) An individual's voluntary election under this subsection--

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under [section 1395d\(d\)\(2\)](#) of this title;

(B) shall be for such a period or periods (which need not be the same periods described in [section 1395d\(d\)\(1\)](#) of this title) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of an individual--

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of subchapter XVIII of this chapter and has elected, under [section 1395d\(d\)](#) of this title, to receive hospice care under such part, and

(C) with respect to whom the hospice program under such subchapter and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in [section 1396a\(a\)\(13\)\(B\)](#) of this title and, if the individual is an individual described in [section 1396a\(a\)\(10\)\(A\)](#) of this title, shall provide for payment of any coinsurance amounts imposed under [section 1395e\(a\)\(4\)](#) of this title.

(p) Qualified medicare beneficiary; medicare cost-sharing

(1) The term "qualified medicare beneficiary" means an individual--

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under [section 1395i-2](#) of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under [section 1395i-2a](#) of this title),

(B) whose income (as determined under [section 1382a](#) of this title for purposes of the supplemental security income program except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under [section 1382b](#) of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum re-

source level applied for the year under subparagraph (D) of section 1395w-114(a)(3) of this title (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with [section 9902\(2\)](#) of this title) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after--

(i) January 1, 1989, is 85 percent,

(ii) January 1, 1990, is 90 percent, and

(iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under [section 1396a\(f\)](#) of this title and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under subchapter XVI of this chapter, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after--

(i) January 1, 1989, is 80 percent,

(ii) January 1, 1990, is 85 percent,

(iii) January 1, 1991, is 95 percent, and

(iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under subchapter II of this chapter for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such subchapter which have occurred pursuant to [section 415\(i\)](#) of this title for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term "transition month" means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term "medicare cost-sharing" means (subject to [section 1396a\(n\)\(2\)](#) of this title) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under [section 1395i-2](#) or [1395i-2a](#) of this title, and

(ii) premiums under [section 1395r](#) of this title, [\[FN4\]](#)

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in [section 1395e](#) of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in [section 1395e](#) and [section 1395\(b\)](#) of this title).

(D) The difference between the amount that is paid under [section 1395\(a\)](#) of this title and the amount that would be paid under such section if any reference to “80 percent” therein were deemed a reference to “100 percent”.

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under [section 1395mm](#) of this title.

(4) Notwithstanding any other provision of this subchapter, in the case of a State (other than the 50 States and the District of Columbia)--

(A) the requirement stated in [section 1396a\(a\)\(10\)\(E\)](#) of this title shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B) or [\[FN5\]](#) 1396a(a)(10)(E)(iii) [\[FN6\]](#) of such paragraph any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under [section 1315](#) of this title, the Secretary shall require the State to meet the requirement of [section 1396a\(a\)\(10\)\(E\)](#) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this title in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally. The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under [section 426](#) or [426-1](#) of this title and shall make the translated forms available to the States and to the Commissioner of Social Security.

(B) In developing such form, the Secretary shall consult with beneficiary groups and the States.

(6) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see [section 1320b-14](#) of this title.

(q) Qualified severely impaired individual

The term “qualified severely impaired individual” means an individual under age 65--

(I) who for the month preceding the first month to which this subsection applies to such individual--

(A) received (i) a payment of supplemental security income benefits under [section 1382\(b\)](#) of this title on the basis of blindness or disability, (ii) a supplementary payment under [section 1382e](#) of this title or under [section 212 of Public Law 93-66](#) on such basis, (iii) a payment of monthly benefits under [section 1382h\(a\)](#) of this title, or (iv) a supplementary payment under [section 1382e\(c\)\(3\)](#) of this title, and

(B) was eligible for medical assistance under the State plan approved under this subchapter; and

(2) with respect to whom the Commissioner of Social Security determines that--

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under subchapter XVI of this chapter,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under [section 1382\(b\)](#) of this title (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this subchapter would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under subchapter XVI of this chapter (including any federally administered State supplementary payments), this subchapter, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to [section 1382h\(b\)](#) of this title in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) Early and periodic screening, diagnostic, and treatment services

The term “early and periodic screening, diagnostic, and treatment services” means the following items and services:

(1) Screening services--

(A) which are provided--

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in [section 1396s\(c\)\(2\)\(B\)\(i\)](#) of this title for pediatric vaccines, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include--

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations (according to the schedule referred to in [section 1396s\(c\)\(2\)\(B\)\(i\)](#) of this title for pediatric vaccines) according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(v) health education (including anticipatory guidance).

(2) Vision services--

(A) which are provided--

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services--

(A) which are provided--

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services--

(A) which are provided--

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation

goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

(s) Qualified disabled and working individual

The term “qualified disabled and working individual” means an individual--

(1) who is entitled to enroll for hospital insurance benefits under part A of subchapter XVIII of this chapter under [section 1395i-2a](#) of this title;

(2) whose income (as determined under [section 1382a](#) of this title for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with [section 9902\(2\)](#) of this title) applicable to a family of the size involved;

(3) whose resources (as determined under [section 1382b](#) of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under subchapter XVI of this chapter; and

(4) who is not otherwise eligible for medical assistance under this subchapter.

(t) “Primary care case management services”, “primary care case manager”, “primary care case management contract”, and “primary care” defined

(1) The term “primary care case management services” means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term “primary care case manager” means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option--

(i) a nurse practitioner (as described in subsection (a)(21) of this section);

(ii) a certified nurse-midwife (as defined in [section 1395x\(gg\)](#) of this title); or

(iii) a physician assistant (as defined in [section 1395x\(aa\)\(5\)](#) of this title).

(3) The term “primary care case management contract” means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which--

(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this subchapter;

(E) provides for a right for an enrollee to terminate enrollment in accordance with [section 1396u-2\(a\)\(4\)](#) of this title; and

(F) complies with the other applicable provisions of [section 1396u-2](#) of this title.

(4) For purposes of this subsection, the term “primary care” includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

(u) Conditions for State plans

(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of [section 1397ee\(d\)\(1\)](#) of this title.

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b) of this section.

(2)(A) For purposes of subsection (b) of this section, the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

(B) For purposes of this paragraph, the term “optional targeted low-income child” means a targeted low-income child as defined in [section 1397jj\(b\)\(1\)](#) of this title (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this subchapter) who would not qualify for medical assistance under the State plan under this subchapter as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of [section 1396a\(l\)\(1\)\(D\)](#)) of this title. Such term excludes any child eligible for medical assistance only by reason of [section 1396a\(a\)\(10\)\(A\)\(ii\)\(XIX\)](#) of this title.

(3) For purposes of subsection (b) of this section, the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in [section 1396a\(l\)\(1\)\(D\)](#) of this title if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this subchapter based on such State plan as in effect as of March 31, 1997.

(4) The limitations on payment under [subsections \(f\) and \(g\) of section 1308](#) of this title shall not apply to Federal payments made under [section 1396b\(a\)\(1\)](#) of this title based on an enhanced FMAP described in [section 1397ee\(b\)](#) of this title.

(v) “Employed individuals with a medically improved disability” defined

(1) The term “employed individual with a medically improved disability” means an individual who

(A) is at least 16, but less than 65, years of age;

(B) is employed (as defined in paragraph (2));

(C) ceases to be eligible for medical assistance under [section 1396a\(a\)\(10\)\(A\)\(ii\)\(XV\)](#) of this title because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under [section 423\(d\)](#) or [1382c\(a\)\(3\)](#) of this title; and

(D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.

(2) For purposes of paragraph (1), an individual is considered to be “employed” if the individual

(A) is earning at least the applicable minimum wage requirement under [section 206 of Title 29](#) and working at least 40 hours per month; or

(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.

(w) “Independent foster care adolescent” defined

(1) For purposes of this subchapter, the term “independent foster care adolescent” means an individual--

(A) who is under 21 years of age;

(B) who, on the individual's 18th birthday, was in foster care under the responsibility of a State; and

(C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under [section 1396u-1\(b\)](#) of this title.

(3) A State may limit the eligibility of independent foster care adolescents under [section 1396a\(a\)\(10\)\(A\)\(ii\)\(XVII\)](#) of this title to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of subchapter IV of this chapter [[42 U.S.C.A. § 670 et seq.](#)] before the date the individuals attained 18 years of age.

(x) For purposes of subsection (a)(27) of this section, the strategies, treatment, and services described in that subsection include the following:

(1) Chronic blood transfusion (with deferoxamine chelation) to prevent stroke in individuals with Sickle Cell Disease who have been identified as being at high risk for stroke.

(2) Genetic counseling and testing for individuals with Sickle Cell Disease or the sickle cell trait to allow health care professionals to treat such individuals and to prevent symptoms of Sickle Cell Disease.

(3) Other treatment and services to prevent individuals who have Sickle Cell Disease and who have had a stroke from having another stroke.

[FN1] So in original. Probably means the subsec. (aa) of [42 U.S.C.A. § 1396a](#) relating to certain breast or cervical cancer patients.

[FN2] So in original. Probably should be “a”.

[FN3] So in original. Probably should be clause “(iii),”. See References in Text note below.

[FN4] So in original. The comma probably should be a period.

[FN5] So in original. Probably should be “or section”.

[FN6] So in original. The phrase “or 1396a(a)(10)(E)(iii)” probably should appear after “of such paragraph”.

§ 1396e. Enrollment of individuals under group health plans

(a) Requirements of each State plan; guidelines

Each State plan--

(1) may implement guidelines established by the Secretary, consistent with subsection (b) of this section, to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this subchapter in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2) of this section);

(2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this subchapter and subject to subsection (b)(2) of this section, notwithstanding any other provision of this subchapter, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and

(3) in the case of such enrollment (except as provided in subsection (c)(1)(B) of this section), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this subchapter (exceeding the amount otherwise permitted under [section 1396o](#) of this title), and shall treat coverage under the group health plan as a third party liability (under [section 1396a\(a\)\(25\)](#) of this title).

(b) Timing of enrollment; failure to enroll

(1) In establishing guidelines under subsection (a)(1) of this section, the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

(2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2) of this section, such failure shall not affect the child's eligibility for benefits under this subchapter.

(c) Premiums considered payments for medical assistance; eligibility

(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of [section 1396b\(a\)](#) of this title, to be payments for medical assistance.

(B) If all members of a family are not eligible for medical assistance under this subchapter and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible--

(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but

(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.

(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as [section 1396a\(a\)\(25\)](#) of this title provides that payment for such benefits shall first be made by such plan.

(d) Repealed. Pub. L. 105-33, Title IV, § 4741(b)(2), Aug. 5, 1997, 111 Stat. 523

(e) Definitions

In this section:

(1) The term “group health plan” has the meaning given such term in [section 5000\(b\)\(1\) of the Internal Revenue Code of 1986](#), and includes the provision of continuation coverage by such a plan pursuant to title XXII of the Public Health Service Act [[42 U.S.C.A. § 300bb-1 et seq.](#)], [section 4980B of the Internal Revenue Code](#) of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

(2) The term “cost-effective” means, as established by the Secretary, that the reduction in expenditures under this subchapter with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment.

§ 1396e-1. Premium assistance option for children

(a) In general

A State may elect to offer a premium assistance subsidy (as defined in subsection (c)) for qualified employer-sponsored coverage (as defined in subsection (b)) to all individuals under age 19 who are entitled to medical assistance under this subchapter (and to the parent of such an individual) who have access to such coverage if the State meets the requirements of this section.

(b) Qualified employer-sponsored coverage

(1) In general

Subject to paragraph (2)), in this paragraph, the term “qualified employer-sponsored coverage” means a group health plan or health insurance coverage offered through an employer--

(A) that qualifies as creditable coverage as a group health plan under 300gg(c)(1) of this title;

(B) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

(C) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of [paragraph \(3\)\(A\)\(ii\) of section 105\(h\) of Title 26](#) (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

(2) Exception

Such term does not include coverage consisting of--

(A) benefits provided under a health flexible spending arrangement (as defined in [section 106\(c\)\(2\) of Title 26](#)); or

(B) a high deductible health plan (as defined in section 223(c)(2) of such title), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such title).

(3) Treatment as third party liability

The State shall treat the coverage provided under qualified employer-sponsored coverage as a third party liability under [section 1396a\(a\)\(25\)](#) of this title.

(c) Premium assistance subsidy

In this section, the term “premium assistance subsidy” means the amount of the employee contribution for enrollment in the qualified employer-sponsored coverage by the individual under age 19 or by the individual's family. Premium assistance subsidies under this section shall be considered, for purposes of [section 1396b\(a\)](#) of this title, to be a payment for medical assistance.

(d) Voluntary participation

(1) Employers

Participation by an employer in a premium assistance subsidy offered by a State under this section shall be voluntary. An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee.

(2) Beneficiaries

No subsidy shall be provided to an individual under age 19 under this section unless the individual (or the individual's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of medical assistance. State may not require, as a condition of an individual under age 19 (or the individual's parent) being or remaining eligible for medical assistance under this subchapter, apply for enrollment in qualified employer-sponsored coverage under this section.

(3) Opt-out permitted for any month

A State shall establish a process for permitting the parent of an individual under age 19 receiving a premium assistance

subsidy to disenroll the individual from the qualified employer-sponsored coverage.

(e) Requirement to pay premiums and cost-sharing and provide supplemental coverage

In the case of the participation of an individual under age 19 (or the individual's parent) in a premium assistance subsidy under this section for qualified employer-sponsored coverage, the State shall provide for payment of all enrollee premiums for enrollment in such coverage and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this subchapter (exceeding the amount otherwise permitted under [section 1396o](#) or, if applicable, [section 1396o-1](#) of this title). The fact that an individual under age 19 (or a parent) elects to enroll in qualified employer-sponsored coverage under this section shall not change the individual's (or parent's) eligibility for medical assistance under the State plan, except insofar as [section 1396a\(a\)\(25\)](#) of this title provides that payments for such assistance shall first be made under such coverage.”

[§ 1396f. Observance of religious beliefs](#)

Nothing in this subchapter shall be construed to require any State which has a plan approved under this subchapter to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

[§ 1396g. State programs for licensing of administrators of nursing homes](#)

(a) Nature of State program

For purposes of [section 1396a\(a\)\(29\)](#) of this title, a “State program for the licensing of administrators of nursing homes” is a program which provides that no nursing home within the State may operate except under the supervision of an administrator licensed in the manner provided in this section.

(b) Licensing by State agency or board representative of concerned professions and institutions

Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of chronically ill and infirm aged patients and established to carry out the purposes of this section.

(c) Functions and duties of State agency or board

It shall be the function and duty of such agency or board to--

(1) develop, impose, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator, which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators;

(2) develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

(3) issue licenses to individuals determined, after the application of such techniques, to meet such standards, and revoke or

suspend licenses previously issued by the board in any case where the individual holding any such license is determined substantially to have failed to conform to the requirements of such standards;

(4) establish and carry out procedures designed to insure that individuals licensed as nursing home administrators will, during any period that they serve as such, comply with the requirements of such standards;

(5) receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the board to the effect that any individual licensed as a nursing home administrator has failed to comply with the requirements of such standards; and

(6) conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of the standards imposed for the licensing of such administrators and of procedures and methods for the enforcement of such standards with respect to administrators of nursing homes who have been licensed as such.

(d) Waiver of standards other than good character or suitability standards

No State shall be considered to have failed to comply with the provisions of [section 1396a\(a\)\(29\)](#) of this title because the agency or board of such State (established pursuant to subsection (b) of this section) shall have granted any waiver, with respect to any individual who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in [section 1396a\(a\)\(29\)](#) of this title are first met by the State, has served as a nursing home administrator, of any of the standards developed, imposed, and enforced by such agency or board pursuant to subsection (c) of this section.

(e) “Nursing home” and “nursing home administrator” defined

As used in this section, the term--

(1) “nursing home” means any institution or facility defined as such for licensing purposes under State law, or, if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary, but does not include a religious nonmedical health care institution (as defined in [section 1395x\(ss\)\(1\)](#) of this title). [\[FN1\]](#)

(2) “nursing home administrator” means any individual who is charged with the general administration of a nursing home whether or not such individual has an ownership interest in such home and whether or not his functions and duties are shared with one or more other individuals.

[\[FN1\]](#) So in original. The period probably should be “; and”.

[§ 1396g-1. Required laws relating to medical child support](#)

(a) In general

The laws relating to medical child support, which a State is required to have in effect under [section 1396a\(a\)\(60\)](#) of this title) [\[FN1\]](#), are as follows:

(1) A law that prohibits an insurer from denying enrollment of a child under the health coverage of the child's parent on the ground that--

(A) the child was born out of wedlock,

(B) the child is not claimed as a dependent on the parent's Federal income tax return, or

(C) the child does not reside with the parent or in the insurer's service area.

(2) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, a law that requires such insurer--

(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this subchapter or part D of subchapter IV of this chapter; and

(C) not to disenroll (or eliminate coverage of) such a child unless the insurer is provided satisfactory written evidence that--

(i) such court or administrative order is no longer in effect, or

(ii) the child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of such disenrollment.

(3) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an employer doing business in the State, a law that requires such employer--

(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this subchapter or part D of subchapter IV of this chapter; and

(C) not to disenroll (or eliminate coverage of) any such child unless--

(i) the employer is provided satisfactory written evidence that--

(I) such court or administrative order is no longer in effect, or

(II) the child is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment, or

(ii) the employer has eliminated family health coverage for all of its employees; and

(D) to withhold from such employee's compensation the employee's share (if any) of premiums for health coverage (except that the amount so withheld may not exceed the maximum amount permitted to be withheld under [section 1673\(b\) of Title 15](#)), and to pay such share of premiums to the insurer, except that the Secretary may provide by regulation for

appropriate circumstances under which an employer may withhold less than such employee's share of such premiums.

(4) A law that prohibits an insurer from imposing requirements on a State agency, which has been assigned the rights of an individual eligible for medical assistance under this subchapter and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

(5) A law that requires an insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent--

(A) to provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage;

(B) to permit the custodial parent (or provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and

(C) to make payment on claims submitted in accordance with subparagraph (B) directly to such custodial parent, the provider, or the State agency.

(6) A law that permits the State agency under this subchapter to garnish the wages, salary, or other employment income of, and requires withholding amounts from State tax refunds to, any person who--

(A) is required by court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under this subchapter,

(B) has received payment from a third party for the costs of such services to such child, but

(C) has not used such payments to reimburse, as appropriate, either the other parent or guardian of such child or the provider of such services,

to the extent necessary to reimburse the State agency for expenditures for such costs under its plan under this subchapter, but any claims for current or past-due child support shall take priority over any such claims for the costs of such services.

(b) "Insurer" defined

For purposes of this section, the term "insurer" includes a group health plan, as defined in [section 1167\(1\) of Title 29](#), a health maintenance organization, and an entity offering a service benefit plan.

[\[FN1\]](#) So in original. The closing parenthesis probably should not appear.

[§ 1396h. State False Claims Act requirements for increased State share of recoveries](#)

(a) In general

Notwithstanding [section 1396d\(b\)](#) of this title, if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

(b) Requirements

For purposes of subsection (a) of this section, the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

- (1) The law establishes liability to the State for false or fraudulent claims described in [section 3729 of Title 31](#), with respect to any expenditure described in [section 1396b\(a\)](#) of this title.
- (2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in [sections 3730 through 3732 of Title 31](#).
- (3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.
- (4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under [section 3729 of Title 31](#).

(c) Deemed compliance

A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) of this section shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

(d) No preclusion of broader laws

Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in [section 3729 of Title 31](#), with respect to programs in addition to the State program under this title, or with respect to expenditures in addition to expenditures described in [section 1396b\(a\)](#) of this title, from being considered to be in compliance with the requirements of subsection (a) of this section so long as the law meets such requirements.

[§ 1396i. Certification and approval of rural health clinics and intermediate care facilities for mentally retarded](#)

(a)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under subchapter XVIII of this chapter, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this subchapter.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

(b)(1) The Secretary may cancel approval of any intermediate care facility for the mentally retarded at any time if he finds on the basis of a determination made by him as provided in [section 1396a\(a\)\(33\)\(B\)](#) of this title that a facility fails to meet the requirements contained in [section 1396a\(a\)\(31\)](#) of this title or [section 1396d\(d\)](#) of this title, or if he finds grounds for termination of his agreement with the facility pursuant to [section 1395cc\(b\)](#) of this title. In that event the Secretary shall notify the State agency and the intermediate care facility for the mentally retarded that approval of eligibility of the facility to participate in the programs established by this subchapter and subchapter XVIII of this chapter shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any intermediate care facility for the mentally retarded which is dissatisfied with a determination by the Secretary that

it no longer qualifies as a [\[FN1\]](#) intermediate care facility for the mentally retarded for purposes of this subchapter, shall be entitled to a hearing by the Secretary to the same extent as is provided in [section 405\(b\)](#) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in [section 405\(g\)](#) of this title, except that, in so applying such sections and in applying [section 405\(l\)](#) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

[\[FN1\]](#) So in original. Probably should be "an".

§ 1396j. Indian Health Service facilities

(a) Eligibility for reimbursement for medical assistance

A facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in [section 1603 of Title 25](#)), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this subchapter.

(b) Facilities deemed to meet requirements upon submission of acceptable plan for achieving compliance

Notwithstanding subsection (a) of this section, a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after September 30, 1976, an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this subchapter), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.

(c) Agreement to reimburse State agency for providing care and services

The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.

(d) Direct billing for payment under medicare, medicaid, and other third party payors

For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this subchapter, see [section 1645 of Title 25](#).

§ 1396k. Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to

recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall--

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required--

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in [section 1396a\(1\)\(1\)\(A\)](#) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under [section 654\(3\)](#) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

§ 1396l. Hospital providers of nursing facility services

(a) Notwithstanding any other provision of this subchapter, payment may be made, in accordance with this section, under a State plan approved under this subchapter for nursing facility services furnished by a hospital which has in effect an agreement under [section 1395tt](#) of this title and which, with respect to the provision of such services, meets the requirements of [subsections \(b\)](#) through [\(d\) of section 1396r](#) of this title.

(b)(1) Except as provided in paragraph (3), payment to any such hospital, for any nursing facility services furnished pursuant to subsection (a) of this section, shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to nursing facilities, respectively, [\[FNI\]](#) located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has an agreement under [section 1395tt](#) of this title, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes

of long-term care patients (including subchapter XVIII of this chapter, this subchapter, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.

(3) Payment to all such hospitals, for any nursing facility services furnished pursuant to subsection (a) of this section, may be made at a payment rate established by the State in accordance with the requirements of [section 1396a\(a\)\(13\)\(A\)](#) of this title.

[FN1] So in original. Probably “, respectively,” should not appear.

§ 1396m. Withholding of Federal share of payments for certain medicare providers

(a) Adjustment of Federal matching payments

The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by--

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under [section 1395cc](#) of this title; and (B)(i) from which the Secretary has been unable to recover overpayments made under subchapter XVIII of this chapter, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under subchapter XVIII of this chapter; and

(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under [section 1395u\(b\)\(3\)\(B\)\(ii\)](#) of this title, and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under subchapter XVIII of this chapter, or submitted claims for payment under subchapter XVIII of this chapter which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under subchapter XVIII of this chapter.

(b) Reductions in payments to and by States

The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this subchapter for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a) of this section, or the total overpayments to such institution or person under subchapter XVIII of this chapter, and may require the State to reduce its payment to such institution or person by such amount.

(c) Notice

The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) of this section until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

(d) Regulations

The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under subchapter XVIII of this chapter, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of

overpayments under subchapter XVIII of this chapter and to which the institution or person would otherwise be entitled under this subchapter.

(e) Restoration to trust funds of recovered amounts

The Secretary shall restore to the trust funds established under [sections 1395j](#) and [1395t](#) of this title, as appropriate, amounts recovered under this section as setoffs against overpayments under subchapter XVIII of this chapter.

(f) Liability of States for withheld payments

Notwithstanding any other provision of this subchapter, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this subchapter which is withheld by the State agency pursuant to an order by the Secretary under subsection (b) of this section.

§ 1396n. Compliance with State plan and payment provisions

(a) Activities deemed as compliance

A State shall not be deemed to be out of compliance with the requirements of [paragraphs \(1\), \(10\), or \(23\) of section 1396a\(a\)](#) of this title solely by reason of the fact that the State (or any political subdivision thereof)--

(1) has entered into--

(A) a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in [section 1396d\(a\)\(3\)](#) of this title or medical devices if the Secretary has found that--

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories--

(I) which meet the applicable requirements of [section 1395x\(e\)\(9\)](#) of this title or paragraphs (16) and (17) [\[FN1\]](#) of [section 1395x\(s\)](#) of this title, and such additional requirements as the Secretary may require, and

(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this subchapter or under part A or part B of subchapter XVIII of this chapter; or

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if--

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

(b) Waivers to promote cost-effectiveness and efficiency

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of [section 1396a](#) of this title (other than subsection (s) of this section) [\[FN2\]](#) (other than [sections 1396a\(a\)\(15\)](#), [1396a\(bb\)](#), and [1396a\(a\)\(10\)\(A\)](#) of this title insofar as it requires provision of the care and services described in [section 1396d\(a\)\(2\)\(C\)](#) of this title) as may be necessary for a State--

(1) to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this subchapter) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this subchapter) in selecting among competing health care plans, if such restriction does not substantially impair access to services of adequate quality where medically necessary,

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this subchapter) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards shall be consistent with the requirements of [section 1396r-4](#) of this title and are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under [section 1396a\(a\)\(37\)\(A\)](#) of this title.

No waiver under this subsection may restrict the choice of the individual in receiving services under [section 1396d\(a\)\(4\)\(C\)](#) of this title.

(c) Waiver respecting medical assistance requirement in State plan: scope, etc.; “habilitation services” defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term “room and board” shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that--

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who--

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of [section 1396a\(a\)\(1\)](#) of this title (relating to statewideness), [section 1396a\(a\)\(10\)\(B\)](#) of this title (relating to comparability), and [section 1396a\(a\)\(10\)\(C\)\(i\)\(III\)](#) of this title (relating to income and resource rules applicable in the community). A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)--

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the

approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.

(5) For purposes of paragraph (4)(B), the term “habilitation services”--

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include--

(i) special education and related services (as such terms are defined in [section 1401 of Title 20](#)), which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under [section 730 of Title 29](#).

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.

(8) The State agency administering the plan under this subchapter may, whenever appropriate, enter into cooperative ar-

rangements with the State agency responsible for administering the program for children with special health care needs under subchapter V of this chapter in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

(d) Home and community-based services for elderly

(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term “room and board” shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that--

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) with respect to individuals 65 years of age or older who--

(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of [section 1396a\(a\)\(1\)](#) of this title (relating to statewideness), [section 1396a\(a\)\(10\)\(B\)](#) of this title (relating to comparability), and [section 1396a\(a\)\(10\)\(C\)\(i\)\(III\)](#) of this title (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c) of this section.

(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of [section 1396b](#) of this title to the contrary, the total amount expended by the State for medical assistance with respect to skilled nursing facility services, intermediate care facility services, and home and community-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

(i) The aggregate amount of the State's medical assistance under this subchapter for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of--

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(ii) The aggregate amount of the State's medical assistance under this subchapter for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of--

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)--

(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise home and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period.

The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period. Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the “lesser of 7 percent” shall be deemed to be a reference to the “greater of 7 percent”.

(iv) If there is enacted after December 22, 1987, an Act which amends this subchapter whose provisions become effective on or after such date and which results in an increase in the aggregate amount of medical assistance under this subchapter for nursing facility services and home and community-based services for individuals who have attained the age of 65 years, the Secretary, at the request of a State with a waiver under this subsection for a waiver year or years and in close consultation with the State, shall adjust the projected amount computed under this subparagraph for the waiver year or years to take into account such increase.

(C) In this paragraph:

(i) The term “home and community-based services” includes services described in [sections 1396d\(a\)\(7\)](#) and [1396d\(a\)\(8\)](#) of this title, services described in subsection (c)(4)(B) of this section, services described in paragraph (4), and personal care services.

(ii)(I) Subject to subclause (II), the term “base year” means the most recent year (ending before December 22, 1987) for which actual final expenditures under this subchapter have been reported to, and accepted by, the Secretary.

(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before December 22, 1987, the term “base year” means fiscal year 1989.

(iii) The term “intermediate care facility services” does not include services furnished in an institution certified in accordance with [section 1396d\(d\)](#) of this title.

(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under [section 1316\(b\)](#) of this title.

(B) Notwithstanding any other provision of this chapter, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with re-

spect to such review).

(e) Waiver for children infected with AIDS or drug dependent at birth

(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as “medical assistance” under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

(B) Children described in this subparagraph are individuals under 5 years of age who--

(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

(ii) have such syndrome, or

(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of subchapter IV of this chapter.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that--

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of [section 1396a\(a\)\(1\)](#) of this title (relating to statewideness) and [section 1396a\(a\)\(10\)\(B\)](#) of this title (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

(4) The provisions of paragraph (6) of subsection (d) of this section shall apply to this subsection in the same manner as it applies to subsection (d) of this section.

(f) Monitor of implementation of waivers; termination of waiver for noncompliance; time limitation for action on requests for plan approval, amendments, or waivers

(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this subchapter submitted by the State pursuant to a provision of this subchapter shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(g) Optional targeted case management services

(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of [section 1396a\(a\)\(1\)](#) of this title and [section 1396a\(a\)\(10\)\(B\)](#) of this title. The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of [section 1396a\(a\)\(23\)](#) of this title. A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, or to individuals described in [section 1396a\(z\)\(1\)\(A\)](#) of this title and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection:

(A)(i) The term “case management services” means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

(ii) Such term includes the following:

(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

(aa) Taking client history.

(bb) Identifying the needs of the individual, and completing related documentation.

(cc) Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

(II) Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

(III) Referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

(IV) Monitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as--

(aa) whether services are being furnished in accordance with an individual's care plan;

(bb) whether the services in the care plan are adequate; and

(cc) whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

(iii) Such term does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including, with respect to the direct delivery of foster care services, services such as (but not limited to) the following:

(I) Research gathering and completion of documentation required by the foster care program.

(II) Assessing adoption placements.

(III) Recruiting or interviewing potential foster care parents.

(IV) Serving legal papers.

(V) Home investigations.

(VI) Providing transportation.

(VII) Administering foster care subsidies.

(VIII) Making placement arrangements.

(B) The term “targeted case management services” are case management services that are furnished without regard to the requirements of [section 1396a\(a\)\(1\)](#) of this title and [section 1396a\(a\)\(10\)\(B\)](#) of this title to specific classes of individuals or to individuals who reside in specified areas.

(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not part of the target population specified in the State plan, such contacts--

(A) are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual's care; and

(B) are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual's needs and care.

(4)(A) In accordance with [section 1396a\(a\)\(25\)](#) of this title, Federal financial participation only is available under this title for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A-87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.

(5) Nothing in this subsection shall be construed as affecting the application of rules with respect to third party liability under programs, or activities carried out under title XXVI of the Public Health Service Act [[42 U.S.C.A. § 300ff-11 et seq.](#)] or by the Indian Health Service.

(h) Period of waivers; continuations

No waiver under this section (other than a waiver under subsection (c), (d), or (e) of this section) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(i) State plan amendment option to provide home and community-based services for elderly and disabled individuals

(1) In general

Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c) of this section for which the Secretary has the authority to approve a waiver and not including room and board or such other services requested by the State as the Secretary may approve) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in [section 1397jj\(c\)\(5\)](#) of this title), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

(A) Needs-based criteria for eligibility for, and receipt of, home and community-based services

The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

(B) Establishment of more stringent needs-based eligibility criteria for institutionalized care

The State establishes needs-based criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under subparagraph (A) for deter-

mining eligibility for home and community-based services.

(C) Projection of number of individuals to be provided home and community-based services

(i) In general

The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

(ii) Authority to limit number of eligible individuals

A State may limit the number of individuals who are eligible for such services and may establish waiting lists for the receipt of such services.

(D) Criteria based on individual assessment

(i) In general

The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in [section 7702B\(c\)\(2\)\(B\) of Title 26](#) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

(ii) Adjustment authority

The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if--

(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services; and

(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under subparagraph (B).

(E) Independent evaluation and assessment

(i) Eligibility determination

The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

(ii) Assessment

In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to--

- (I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;
- (II) prevent the provision of unnecessary or inappropriate care; and
- (III) establish an individualized care plan for the individual in accordance with subparagraph (G).

(F) Assessment

The independent assessment required under subparagraph (E)(ii) shall include the following:

- (i) An objective evaluation of an individual's inability to perform 2 or more activities of daily living (as defined in [section 7702B\(c\)\(2\)\(B\) of Title 26](#)) or the need for significant assistance to perform such activities.
- (ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.
- (iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.
- (iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.
- (v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.
- (vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

(G) Individualized care plan

(i) In general

In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

(ii) Plan requirements

The State ensures that the individualized care plan for an individual--

(I) is developed--

- (aa) in consultation with the individual, the individual's treating physician, health care or support professional, or

other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

(bb) taking into account the extent of, and need for, any family or other supports for the individual;

(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

(iii) State option to offer election for self-directed services

(I) Individual choice

At the option of the State, the State may allow an individual or the individual's representative to elect to receive self-directed home and community-based services in a manner which gives them the most control over such services consistent with the individual's abilities and the requirements of subclauses (II) and (III).

(II) Self-directed services

The term "self-directed" means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

(aa) Assessment

There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(bb) Service plan

Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

(III) Plan requirements

For purposes of subclause (II)(bb), the requirements of this subclause are that the plan--

(aa) specifies those services which the individual or the individual's authorized representative would be responsible for directing;

(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(IV) Budget process

With respect to individualized budgets described in subclause (III)(ff), the State plan amendment--

(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(cc) provides a procedure to evaluate expenditures under such budgets.

(H) Quality assurance; conflict of interest standards

(i) Quality assurance

The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

(ii) Conflict of interest standards

The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

(I) Redeterminations and appeals

The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(J) Presumptive eligibility for assessment

The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

(2) Definition of individual's representative

In this section, the term “individual's representative” means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

(3) Nonapplication

A State may elect in the State plan amendment approved under this section to not comply with the requirements of [section 1396a\(a\)\(1\)](#) of this title (relating to statewideness) and [section 1396a\(a\)\(10\)\(C\)\(i\)\(III\)](#) of this title (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.

(4) No effect on other waiver authority

Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under [section 1315](#) of this title.

(5) Continuation of Federal financial participation for medical assistance provided to individuals as of effective date of State plan amendment

Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or [section 1315](#) of this title that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph, until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.

(j)(1) A State may provide, as “medical assistance”, payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under subsection (c) of this section. Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the program, and to assure financial accountability for funds expended with respect to such services.

(B) The State will provide, with respect to individuals who--

(i) are entitled to medical assistance for personal care services under the plan, or receive home and community-based

services under a waiver granted under subsection (c) of this section;

(ii) may require self-directed personal assistance services; and

(iii) may be eligible for self-directed personal assistance services,

an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c) of this section.

(C) Such individuals who are determined to be likely to require personal care under the plan, or home and community-based services under a waiver granted under subsection (c) of this section are informed of the feasible alternatives, if available under the State's self-directed personal assistance services program, at the choice of such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c) of this section.

(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of [section 1396a\(a\)\(1\)](#) of this title and may limit the population eligible to receive these services and limit the number of persons served without regard to [section 1396a\(a\)\(10\)\(B\)](#) of this title.

(4)(A) For purposes of this subsection, the term “self-directed personal assistance services” means personal care and related services, or home and community-based services otherwise available under the plan under this subchapter or subsection (c) of this section, that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing such services.

(B) At the election of the State--

(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

(ii) the individual may use the individual's budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(5) For purpose of this section, the term “approved self-directed services plan and budget” means, with respect to a participant, the establishment of a plan and budget for the provision of self-directed personal assistance services, consistent with the following requirements:

(A) Self-direction

The participant (or in the case of a participant who is a minor child, the participant's parent or guardian, or in the case of an incapacitated adult, another individual recognized by State law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

(B) Assessment of needs

There is an assessment of the needs, strengths, and preferences of the participants for such services.

(C) Service plan

A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that--

(i) builds upon the participant's capacity to engage in activities that promote community life and that respects the participant's preferences, choices, and abilities; and

(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

(D) Service budget

A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

(E) Application of quality assurance and risk management

There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant's resources and capabilities.

(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in [section 1396b\(a\)](#) of this title.

[\[FN1\]](#) See Codifications note set out under this section.

[\[FN2\]](#) So in original.

[§ 1396o. Use of enrollment fees, premiums, deductions, cost sharing, and similar charges](#)

(a) Imposition of certain charges under plan in case of individuals described in section 1396a(a)(10)(A) or (E)(i)

Subject to subsections (g), (i), and (j), the State plan shall provide that in the case of individuals described in [subparagraph \(A\)](#) or [\(E\)\(i\) of section 1396a\(a\)\(10\)](#) of this title who are eligible under the plan--

(1) no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c) of this section);

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to--

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in [section 1396d\(a\)\(4\)\(C\)](#) of this title, or

(E) services furnished to an individual who is receiving hospice care (as defined in [section 1396d\(o\)](#) of this title); and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of "nominal" under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(b) Imposition of certain charges under plan in case of individuals other than those described in [section 1396a\(a\)\(10\)\(A\)](#) or (E)

The State plan shall provide that in the case of individuals other than those described in [subparagraph \(A\)](#) or [\(E\) of section 1396a\(a\)\(10\)](#) of this title who are eligible under the plan--

(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income,

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to--

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in [section 1396d\(a\)\(4\)\(C\)](#) of this title, or

(E) services furnished to an individual who is receiving hospice care (as defined in [section 1396d\(o\)](#) of this title); and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of “nominal” under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(c) Imposition of monthly premium; persons affected; amount; prepayment; failure to pay; use of funds from other programs

(1) The State plan of a State may at the option of the State provide for imposing a monthly premium (in an amount that does not exceed the limit established under paragraph (2)) with respect to an individual described in [subparagraph \(A\) or \(B\) of section 1396a\(l\)\(1\)](#) of this title who is receiving medical assistance on the basis of [section 1396a\(a\)\(10\)\(A\)\(ii\)\(IX\)](#) of this title and whose family income (as determined in accordance with the methodology specified in [section 1396a\(l\)\(3\)](#) of this title) equals or exceeds 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with [section 9902\(2\)](#) of this title) applicable to a family of the size involved.

(2) In no case may the amount of any premium imposed under paragraph (1) exceed 10 percent of the amount by which the family income (less expenses for the care of a dependent child) of an individual exceeds 150 percent of the line described in paragraph (1).

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(4) A State may permit State or local funds available under other programs to be used for payment of a premium imposed under paragraph (1). Payment of a premium with such funds shall not be counted as income to the individual with respect to whom such payment is made.

(d) Premiums for qualified disabled and working individuals described in [section 1396d\(s\)](#)

With respect to a qualified disabled and working individual described in [section 1396d\(s\)](#) of this title whose income (as determined under paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in [section 1396d\(p\)\(3\)\(A\)\(i\)](#) of this title provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments (as determined by the Secretary), as the individual's income increases from 150 percent of such poverty line to 200 percent of such poverty line.

(e) Prohibition of denial of services on basis of individual's inability to pay certain charges

The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. The requirements of this subsection shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost sharing, or similar charge.

(f) Charges imposed under waiver authority of Secretary

No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3) of this section and [section 1396o-1](#) of this title, unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment--

(1) will test a unique and previously untested use of copayments,

(2) is limited to a period of not more than two years,

(3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,

(4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

(5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

(g) State authority to impose income-related premiums and cost sharing

With respect to individuals provided medical assistance only under subclause (xv) or (xvi) of section 1396a(a)(10)(a)(ii) of this title--

(1) a State may (in a uniform manner for individuals described in either such subclause)--

(A) require such individuals to pay premiums or other cost-sharing charges set on a sliding scale based on income that the State may determine; and

(B) require payment of 100 percent of such premiums for such year in the case of such an individual who has income for a year that exceeds 250 percent of the income official poverty line (referred to in subsection (c)(1)) applicable to a family of the size involved, except that in the case of such an individual who has income for a year that does not exceed 450 percent of such poverty line, such requirement may only apply to the extent such premiums do not exceed 7.5 percent of such income; and

(2) such State shall require payment of 100 percent of such premiums for a year by such an individual whose adjusted gross income (as defined in [section 62 of the Internal Revenue Code of 1986](#)) for such year exceeds \$75,000, except that a State may choose to subsidize such premiums by using State funds which may not be federally matched under this title.

In the case of any calendar year beginning after 2000, the dollar amount specified in paragraph (2) shall be increased in accordance with the provisions of [section 415\(i\)\(2\)\(A\)\(ii\)](#) of this title.

(h) In applying this section and [subsections \(c\) and \(e\) of section 1396o-1](#) of this title, with respect to cost sharing that is “nominal” in amount, the Secretary shall increase such “nominal” amounts for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner.

(i)(1) With respect to disabled children provided medical assistance under [section 1396a\(a\)\(10\)\(A\)\(ii\)\(XIX\)](#) of this title, subject to paragraph (2), a State may (in a uniform manner for such children) require the families of such children to pay monthly premiums set on a sliding scale based on family income.

(2) A premium requirement imposed under paragraph (1) may only apply to the extent that

(A) in the case of a disabled child described in that paragraph whose family income--

(i) does not exceed 200 percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under [section 1396a\(cc\)\(2\)\(A\)\(i\)](#) of this title and other cost-sharing charges do not exceed 5 percent of the family's income; and

(ii) exceeds 200, but does not exceed 300, percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under [section 1396a\(cc\)\(2\)\(A\)\(i\)](#) of this title and other cost-sharing charges do not exceed 7.5 percent of the family's income; and

(B) the requirement is imposed consistent with [section 1396a\(cc\)\(2\)\(A\)\(ii\)\(I\)](#) of this title.

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of a child under [section 1396a\(a\)\(10\)\(A\)\(ii\)\(XIX\)](#) of this title for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of at least 60 days from the date on which the premium became past due. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(j) No premiums or cost sharing for Indians furnished items or services directly by Indian health programs or through referral under contract health services

(1) No cost sharing for items or services furnished to Indians through Indian health programs

(A) In general

No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this subchapter.

(B) No reduction in amount of payment to Indian health providers

Payment due under this subchapter to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such subchapter, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

(2) Rule of construction

Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this subchapter who is an Indian.

§ 1396o-1. State option for alternative premiums and cost sharing

(a) State flexibility

(1) In general

Notwithstanding [sections 1396o](#) and [1396a\(a\)\(10\)\(B\)](#) of this title, but subject to paragraph (2), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c) of this section and non-emergency services furnished in a hospital emergency department for which cost sharing may be imposed under subsection (e) of this section), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) [subsection \(g\)](#) or [\(i\) of section 1396o](#) of this title.

(2) Exemption for individuals with family income not exceeding 100 percent of the poverty line

(A) In general

Paragraph (1) and subsection (d) of this section shall not apply, and [sections 1396o](#) and [1396a\(a\)\(10\)\(B\)](#) of this title shall continue to apply, in the case of an individual whose family income does not exceed 100 percent of the poverty line applicable to a family of the size involved.

(B) Limit on aggregate cost sharing

To the extent cost sharing under subsections (c) and (e) of this section or under [section 1396o](#) of this title is imposed against individuals described in subparagraph (A), the limitation under subsection (b)(1)(B)(ii) of this section on the total aggregate amount of cost sharing shall apply to such cost sharing for all individuals in a family described in subparagraph (A) in the same manner as such limitations apply to cost sharing and families described in subsection (b)(1)(B)(ii) of this section.

(3) Definitions

In this section:

(A) Premium

The term “premium” includes any enrollment fee or similar charge.

(B) Cost sharing

The term “cost sharing” includes any deduction, copayment, or similar charge.

(b) Limitations on exercise of authority

(1) Individuals with family income between 100 and 150 percent of the poverty line

In the case of an individual whose family income exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved--

(A) no premium may be imposed under the plan; and

(B) with respect to cost sharing--

(i) the cost sharing imposed under subsection (a) of this section with respect to any item or service may not exceed 10 percent of the cost of such item or service; and

(ii) the total aggregate amount of cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e) of this section) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

(2) Individuals with family income above 150 percent of the poverty line

In the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved--

(A) the total aggregate amount of premiums and cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e) of this section) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State); and

(B) with respect to cost sharing, the cost sharing imposed with respect to any item or service under subsection (a) of this section may not exceed 20 percent of the cost of such item or service.

(3) Additional limitations

(A) Premiums

No premiums shall be imposed under this section with respect to the following:

(i) Individuals under 18 years of age that are required to be provided medical assistance under [section 1396a\(a\)\(10\)\(A\)\(i\)](#) of this title, and including individuals with respect to whom child welfare services are made available under part B of subchapter IV of this chapter on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age.

(ii) Pregnant women.

(iii) Any terminally ill individual who is receiving hospice care (as defined in [section 1396d\(o\)](#) of this title).

(iv) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally re-

tarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(v) Women who are receiving medical assistance by virtue of the application of [sections 1396a\(a\)\(10\)\(A\)\(ii\)\(XVIII\)](#) of this title and 1396a(aa) of this title.

(vi) Disabled children who are receiving medical assistance by virtue of the application of [sections 1396a\(a\)\(10\)\(A\)\(ii\)\(XIX\)](#) and [1396a\(cc\)](#) of this title.

(vii) An Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

(B) Cost sharing

Subject to the succeeding provisions of this section, no cost sharing shall be imposed under subsection (a) with respect to the following:

(i) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under [section 1396a\(a\)\(10\)\(A\)\(i\)](#) of this title, and including services furnished to individuals with respect to whom child welfare services are made available under part B of subchapter IV of this chapter on the basis of being a child in foster care or and individuals with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age.

(ii) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

(iii) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(iv) Services furnished to a terminally ill individual who is receiving hospice care (as defined in [section 1396d\(o\)](#) of this title).

(v) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(vi) Emergency services (as defined by the Secretary for purposes of [section 1396o\(a\)\(2\)\(D\)](#) of this title).

(vii) Family planning services and supplies described in [section 1396d\(a\)\(4\)\(C\)](#) of this title.

(viii) Services furnished to women who are receiving medical assistance by virtue of the application of [sections 1396a\(a\)\(10\)\(A\)\(ii\)\(XVIII\)](#) of this title and 1396a(aa) of this title.

(ix) Services furnished to disabled children who are receiving medical assistance by virtue of the application of [sections 1396a\(a\)\(10\)\(A\)\(ii\)\(XIX\)](#) and [1396a\(cc\)](#) of this title.

(x) Items and services furnished to an Indian directly by the Indian Health Service, an Indian Tribe, Tribal Organiza-

tion or Urban Indian Organization or through referral under contract health services.

(C) Construction

Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals from premiums under this section or from exempting additional individuals or services from cost sharing under subsection (a) of this section.

(4) Determinations of family income

In applying this subsection, family income shall be determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family income shall be determined for such period and at such periodicity as the State may provide under this subchapter.

(5) Poverty line defined

For purposes of this section, the term “poverty line” has the meaning given such term in [section 9902\(2\)](#) of this title, including any revision required by such section.

(6) Construction

Nothing in this section shall be construed--

(A) as preventing a State from further limiting the premiums and cost sharing imposed under this section beyond the limitations provided under this section;

(B) as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost sharing under this section; or

(C) as affecting any such waiver of requirements in effect under this subchapter before February 8, 2006 with regard to the imposition of premiums and cost sharing.

(c) Special rules for cost sharing for prescription drugs

(1) In general

In order to encourage beneficiaries to use drugs (in this subsection referred to as “preferred drugs”) identified by the State as the most (or more) cost effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State, subject to paragraph (2), the State may--

(A) provide cost sharing (instead of the level of cost sharing otherwise permitted under [section 1396o](#) of this title, but subject to paragraphs (2) and (3)) with respect to drugs that are not preferred drugs within a class; and

(B) waive or reduce the cost sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost sharing for such preferred drugs for individuals for whom cost sharing may not be imposed under subsection (a) of this section due to the application of subsection (b)(3)(B) of this section.

(2) Limitations

(A) By income group

In no case may the cost sharing under paragraph (1)(A) with respect to a non-preferred drug exceed--

(i) in the case of an individual whose family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, the amount of nominal cost sharing (as otherwise determined under [section 1396o](#) of this title); or

(ii) in the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, 20 percent of the cost of the drug.

(B) Limitation to nominal for exempt populations

In the case of an individual who is not subject to cost sharing under subsection (a) of this section due to the application of paragraph (1)(B), any cost sharing under paragraph (1)(A) with respect to a non-preferred drug may not exceed a nominal amount (as otherwise determined under [section 1396o](#) of this title).

(C) Continued application of aggregate cap

In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1)(A) continues to be subject to the aggregate cap on cost sharing applied under subsection (a)(2)(B) of this section or under paragraph (1) or (2) of subsection (b) of this section, as the case may be.

(3) Waiver

In carrying out paragraph (1), a State shall provide for the application of cost sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

(4) Exclusion authority

Nothing in this subsection shall be construed as preventing a State from excluding specified drugs or classes of drugs from the application of paragraph (1).

(d) Enforceability of premiums and other cost sharing

(1) Premiums

Notwithstanding [section 1396o\(c\)\(3\)](#) of this title and [section 1396a\(a\)\(10\)\(B\)](#) of this title, a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium but shall not terminate eligibility of an individual for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. A State may apply the previous sentence for some or all groups of beneficiaries as specified by the State and may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(2) Cost sharing

Notwithstanding [section 1396o\(e\)](#) of this title, or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to an individual entitled to medical assistance under this subchapter for such care, items, or services, the payment of any cost sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider from reducing or waiving the application of such cost sharing on a case-by-case basis.

(e) State option for permitting hospitals to impose cost sharing for non-emergency care furnished in an emergency department

(1) In general

Notwithstanding [section 1396o](#) of this title and [section 1396a\(a\)\(1\)](#) of this title or the previous provisions of this section, but subject to the limitations of paragraph (2), a State may, by amendment to its State plan under this subchapter, permit a hospital to impose cost sharing for non-emergency services furnished to an individual (within one or more groups of individuals specified by the State) in the hospital emergency department under this subsection if the following conditions are met:

(A) Access to non-emergency room provider

The individual has actually available and accessible (as such terms are applied by the Secretary under [section 1396o\(b\)\(3\)](#) of this title) an alternate non-emergency services provider with respect to such services.

(B) Notice

The hospital must inform the beneficiary after receiving an appropriate medical screening examination under [section 1395dd](#) of this title and after a determination has been made that the individual does not have an emergency medical condition, but before providing the non-emergency services, of the following:

- (i) The hospital may require the payment of the State specified cost sharing before the service can be provided.
- (ii) The name and location of an alternate non-emergency services provider (described in subparagraph (A)) that is actually available and accessible (as described in such subparagraph).
- (iii) The fact that such alternate provider can provide the services without the imposition of cost sharing described in clause (i).
- (iv) The hospital provides a referral to coordinate scheduling of this treatment.

Nothing in this subsection shall be construed as preventing a State from applying (or waiving) cost sharing otherwise permissible under this section to services described in clause (iii).

(2) Limitations

(A) Individuals with family income between 100 and 150 percent of the poverty line

In the case of an individual described in subsection (b)(1) of this section who is not described in subparagraph (B), the cost sharing imposed under this subsection may not exceed twice the amount determined to be nominal under [section 1396o](#) of this title, subject to the percent of income limitation otherwise applicable under subsection (b)(1)(B)(ii) of this

section.

(B) Application to exempt populations

In the case of an individual described in subsection (a)(2)(A) of this section or who is not subject to cost sharing under subsection (b)(3)(B) of this section with respect to non-emergency services described in paragraph (1), a State may impose cost sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as otherwise determined under [section 1396o](#) of this title) so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.

(C) Continued application of aggregate cap; relation to other cost sharing

In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1) is subject to the aggregate cap on cost sharing applied under subsection (a)(2)(B) of this section or under paragraph (1) or (2) of subsection (b) of this section, as the case may be. Cost sharing imposed for services under this subsection shall be instead of any cost sharing that may be imposed for such services under subsection (a) of this section or [section 1396o](#) of this title.

(3) Construction

Nothing in this section shall be construed--

(A) to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under [section 1395dd](#) of this title; or

(B) to modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

(4) Definitions

For purposes of this subsection:

(A) Non-emergency services

The term “non-emergency services” means any care or services furnished in an emergency department of a hospital that do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under [section 1395dd](#) of this title.

(B) Alternate non-emergency services provider

The term “alternative non-emergency services provider” means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in an emergency department of a hospital for the diagnosis or treatment of a condition, and that is participating in the program under this subchapter.

[§ 1396p. Liens, adjustments and recoveries, and transfers of assets](#)

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except--

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual--

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if--

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in [section 1382c](#) of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of--

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in [section 1396a\(a\)\(10\)\(E\)](#) of this title).

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources--

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term “qualified State long-term care insurance partnership” means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in [section 7702B\(b\) of Title 26](#)) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who--

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under [section 1396a\(a\)\(5\)](#) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such bene-

fits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time--

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in [section 1382c](#) of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when--

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3)(A) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this subchapter for Indians.

(4) For purposes of this subsection, the term “estate”, with respect to a deceased individual--

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(XVII) The provisions of [section 26](#) relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(c)--

(i) the terms “model regulation” and “model Act” mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any

other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

(1)(A) In order to meet the requirements of this subsection for purposes of [section 1396a\(a\)\(18\)](#) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to--

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under [subsection \(c\)](#) or [\(d\) of section 1396n](#) of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in [paragraph \(7\)](#), [\(22\)](#), or [\(24\) of section 1396d\(a\)](#) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan

to individuals requiring long-term care.

(D)(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to--

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to--

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced--

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless--

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child

and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this subchapter unless--

(i) the annuity is--

(I) an annuity described in [subsection \(b\)](#) or [\(q\) of section 408 of Title 26](#); or

(II) purchased with proceeds from--

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such title;

(bb) a simplified employee pension (within the meaning of section 408(k) of such title); or

(cc) a Roth IRA described in section 408A of such title; or

(ii) the annuity--

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (b), a State may determine the period of ineligibility applicable to such individual under this paragraph by--

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage--

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that--

(A) the assets transferred were a home and title to the home was transferred to--

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in [section 1382c](#) of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets--

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in [section 1382c\(a\)\(3\)](#) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the

Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual.

While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under [section 1396a\(f\)](#) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in [section 1382b](#) of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to--

- (i) the purposes for which a trust is established,
- (ii) whether the trustees have or exercise any discretion under the trust,
- (iii) any restrictions on when or whether distributions may be made from the trust, or
- (iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust--

- (i) the corpus of the trust shall be considered resources available to the individual,
- (ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and
- (iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.

(B) In the case of an irrevocable trust--

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income--

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in [section 1382c\(a\)\(3\)](#) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if--

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter, and

(iii) the State makes medical assistance available to individuals described in [section 1396a\(a\)\(10\)\(A\)\(ii\)\(V\)](#) of this title, but does not make such assistance available to individuals for nursing facility services under [section 1396a\(a\)\(10\)\(C\)](#) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in [section 1382c\(a\)\(3\)](#) of this title) that meets the following conditions:

(i) The trust is established and managed by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in [section 1382c\(a\)\(3\)](#) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e)(1) In order to meet the requirements of this section for purposes of [section 1396a\(a\)\(18\)](#) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) of this section (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F) of this section, the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f)(1)(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds \$500,000.

(B) A State may elect, without regard to the requirements of [section 1396a\(a\)\(1\)](#) of this title (relating to statewideness) and [section 1396a\(a\)\(10\)\(B\)](#) of this title (relating to comparability), to apply subparagraph (A) by substituting for “\$500,000”, an amount that exceeds such amount, but does not exceed \$750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

(2) Paragraph (1) shall not apply with respect to an individual if--

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in [section 1382c](#) of this title,

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that--

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term “assets”, with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action--

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term “income” has the meaning given such term in [section 1382a](#) of this title.

(3) The term “institutionalized individual” means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in [section 1396a\(a\)\(10\)\(A\)\(ii\)\(VI\)](#) of this title.

(4) The term “noninstitutionalized individual” means an individual receiving any of the services specified in subsection (c)(1)(C)(ii) of this section.

(5) The term “resources” has the meaning given such term in [section 1382b](#) of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

[§ 1396q. Application of provisions of subchapter II relating to subpoenas](#)

The provisions of [subsections \(d\) and \(e\) of section 405](#) of this title shall apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter, except that, in so applying such subsections, and in applying [section 405\(l\)](#) of this title thereto, with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

[§ 1396r. Requirements for nursing facilities](#)

(a) “Nursing facility” defined

In this subchapter, the term “nursing facility” means an institution (or a distinct part of an institution) which--

(1) is primarily engaged in providing to residents--

(A) skilled nursing care and related services for residents who require medical or nursing care,

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of [section 1395x\(l\)](#) of this title) with one or more hospitals having agreements in effect under [section 1395cc](#) of this title; and

(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), and (d) of this section.

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which--

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment--

- (i)** describes the resident's capability to perform daily life functions and significant impairments in functional capacity;
- (ii)** is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A) of this section;
- (iii)** uses an instrument which is specified by the State under subsection (e)(5) of this section; and
- (iv)** includes the identification of medical problems.

(B) Certification

(i) In general

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 with respect to each assessment.

(III) The provisions of [section 1320a-7a](#) of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) of this section or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general

Such an assessment must be conducted--

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review

The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination

Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort. In addition, a nursing facility shall notify the State mental health authority or State mental retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded.

(F) Requirements relating to preadmission screening for mentally ill and mentally retarded individuals

Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A) of this section, a nursing facility must not admit, on or after January 1, 1989, any new resident who--

(i) is mentally ill (as defined in subsection (e)(7)(G)(i) of this section) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental illness, or

(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii) of this section) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental retardation.

A State mental health authority and a State mental retardation or developmental disability authority may not dele-

gate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(4) Provision of services and activities

(A) In general

To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)--

- (i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;
- (ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;
- (iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;
- (iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;
- (v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;
- (vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and
- (vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

(B) Qualified persons providing services

Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care; facility waivers

(i) General requirements

With respect to nursing facility services provided on or after October 1, 1990, a nursing facility--

- (I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and
- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

(ii) Waiver by State

To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if--

- (I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,
- (II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility,
- (III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,
- (IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965 [[42 U.S.C.A. § 3027\(a\)\(12\)](#)] and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and
- (V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (iii) shall be accepted by the Secretary for purposes of this subchapter to the same extent as is the State's certification of the facility. In granting or renewing a waiver, a State may require the facility to use other qualified, licensed personnel.

(iii) Assumption of waiver authority by Secretary

If the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the State to grant waivers.

(5) Required training of nurse aides

(A) In general

(i) Except as provided in clause (ii), a nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990, for more than 4 months unless the individual--

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A) of this section, and

(II) is competent to provide nursing or nursing-related services.

(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) Offering competency evaluation programs for current employees

A nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) of this section and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

(C) Competency

The nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) of this section that the facility believes will include information concerning the individual.

(D) Re-training required

For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program or a new competency evaluation program.

(E) Regular in-service education

The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) Nurse aide defined

In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual--

- (i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or
- (ii) who volunteers to provide such services without monetary compensation.

(G) Licensed health professional defined

In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(6) Physician supervision and clinical records

A nursing facility must--

(A) require that the health care of every resident be provided under the supervision of a physician (or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an em-

ployee of the facility but who is working in collaboration with a physician);

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)), as well as the results of any pre-admission screening conducted under subsection (e)(7) of this section.

(7) Required social services

In the case of a nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(8) Information on nurse staffing

(A) In general

A nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) Publication of data

A nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed--

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right--

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of subchapter XVIII of this chapter) to a portion of the facility that is such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident.

(B) Notice of rights

A nursing facility must--

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility and of the requirements and procedures for establishing eligibility for medical assistance under this subchapter, including the right to request an assessment under [section 1396r-5\(c\)\(1\)\(B\)](#) of this title;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under subsection (e)(6) of this section;

(iii) inform each resident who is entitled to medical assistance under this subchapter--

(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under [section 1396a\(a\)\(28\)\(B\)](#) of this title) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in [section 1396o](#) of this title), and of those other items and services that the facility offers and for which the resident may be charged and the amount of the charges for such items and services, and

(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under subchapter XVIII of this chapter or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

(2) Transfer and discharge rights

(A) In general

A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless--

- (i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
- (ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- (iii) the safety of individuals in the facility is endangered;
- (iv) the health of individuals in the facility would otherwise be endangered;
- (v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XVIII of this chapter on the resident's behalf) for a stay at the facility; or
- (vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this subchapter after admission to the facility, only charges which may be imposed under this subchapter shall be considered to be allowable.

(B) Pre-transfer and pre-discharge notice

(i) In general

Before effecting a transfer or discharge of a resident, a nursing facility must--

- (I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,
- (II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) Timing of notice

The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except--

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) Items included in notice

Each notice under clause (i) must include--

(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3) of this section;

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [[42 U.S.C.A. § 3021 et seq.](#) or [3058 et seq.](#)] in accordance with section 712 of the Act [[42 U.S.C.A. § 3058g](#)]);

(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 [[42 U.S.C.A. § 15041 et seq.](#)]; and

(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i) of this section), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act [[42 U.S.C.A. § 10801 et seq.](#)].

(C) Orientation

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(D) Notice on bed-hold policy and readmission

(i) Notice before transfer

Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning--

(I) the provisions of the State plan under this subchapter regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

(ii) Notice upon transfer

At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in clause (i).

(iii) Permitting resident to return

A nursing facility must establish and follow a written policy under which a resident--

(I) who is eligible for medical assistance for nursing facility services under a State plan,

(II) who is transferred from the facility for hospitalization or therapeutic leave, and

(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(E) Information respecting advance directives

A nursing facility must comply with the requirement of [section 1396a\(w\)](#) of this title (relating to maintaining written policies and procedures respecting advance directives).

(F) Continuing rights in case of voluntary withdrawal from participation

(i) In general

In the case of a nursing facility that voluntarily withdraws from participation in a State plan under this subchapter [[42 U.S.C.A. § 1396 et seq.](#)] but continues to provide services of the type provided by nursing facilities--

(I) the facility's voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day);

(II) the provisions of this section continue to apply to such residents until the date of their discharge from the facility; and

(III) in the case of each individual who begins residence in the facility after the effective date of such withdrawal, the facility shall provide notice orally and in a prominent manner in writing on a separate page at the time the individual begins residence of the information described in clause (ii) and shall obtain from each such individual at such time an acknowledgment of receipt of such information that is in writing, signed by the individual, and separate from other documents signed by such individual.

Nothing in this subparagraph shall be construed as affecting any requirement of a participation agreement that a nursing facility provide advance notice to the State or the Secretary, or both, of its intention to terminate the agreement.

(ii) Information for new residents

The information described in this clause for a resident is the following:

(I) The facility is not participating in the program under this subchapter [[42 U.S.C.A. § 1396 et seq.](#)] with respect to that resident.

(II) The facility may transfer or discharge the resident from the facility at such time as the resident is unable to pay the charges of the facility, even though the resident may have become eligible for medical assistance for nursing facility services under this subchapter.

(iii) Continuation of payments and oversight authority

Notwithstanding any other provision of this subchapter, with respect to the residents described in clause (i)(I), a participation agreement of a facility described in clause (i) is deemed to continue in effect under such plan after the effective date of the facility's voluntary withdrawal from participation under the State plan for purposes of--

(I) receiving payments under the State plan for nursing facility services provided to such residents;

(II) maintaining compliance with all applicable requirements of this subchapter; and

(III) continuing to apply the survey, certification, and enforcement authority provided under subsections (g) and (h) (including involuntary termination of a participation agreement deemed continued under this clause).

(iv) No application to new residents

This paragraph (other than subclause (III) of clause (i)) shall not apply to an individual who begins residence in a facility on or after the effective date of the withdrawal from participation under this subparagraph.

(3) Access and visitation rights

A nursing facility must--

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) Equal access to quality care

(A) In general

A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

(B) Construction

(i) Nothing prohibiting any charges for non-medicaid patients

Subparagraph (A) shall not be construed as prohibiting a nursing facility from charging any amount for services furnished, consistent with the notice in paragraph (1)(B) describing such charges.

(ii) No additional services required

Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State plan.

(5) Admissions policy

(A) Admission

With respect to admissions practices, a nursing facility must--

(i) (I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or subchapter XVIII of this chapter, (II) subject to subparagraph (B)(v), not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or subchapter XVIII of this chapter, and (III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this subchapter, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the

individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) Construction

(i) No preemption of stricter standards

Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

(ii) Contracts with legal representatives

Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(iii) Charges for additional services requested

Subparagraph (A)(iii) shall not be construed as preventing a facility from charging a resident, eligible for medical assistance under the State plan, for items or services the resident has requested and received and that are not specified in the State plan as included in the term "nursing facility services".

(iv) Bona fide contributions

Subparagraph (A)(iii) shall not be construed as prohibiting a nursing facility from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission, or continued stay in the facility.

(v) Treatment of continuing care retirement communities admission contracts

Notwithstanding subclause (II) of subparagraph (A)(i), subject to [subsections \(c\) and \(d\) of section 1396r-5](#) of this title, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.

(6) Protection of resident funds

(A) In general

The nursing facility--

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) Management of personal funds

Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) Deposit

The facility must deposit any amount of personal funds in excess of \$50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) Accounting and records

The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) Notice of certain balances

The facility must notify each resident receiving medical assistance under the State plan under this subchapter when the amount in the resident's account reaches \$200 less than the dollar amount determined under [section 1382\(a\)\(3\)\(B\)](#) of this title and the fact that if the amount in the account (in addition to the value of the resident's other nonexempt resources) reaches the amount determined under such section the resident may lose eligibility for such medical assistance or for benefits under subchapter XVI of this chapter.

(iv) Conveyance upon death

Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) Assurance of financial security

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) Limitation on charges to personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this subchapter or subchapter XVIII of this chapter.

(7) Limitation on charges in case of medicaid-eligible individuals

(A) In general

A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State under its plan under this subchapter, that exceed the payment amounts established by the State for such services under this subchapter.

(B) "Certain medicaid-eligible individual" defined

In subparagraph (A), the term "certain medicaid-eligible individual" means an individual who is entitled to medical assistance for nursing facility services in the facility under this subchapter but with respect to whom such benefits are not being paid because, in determining the amount of the individual's income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this subchapter.

(8) Posting of survey results

A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g) of this section.

(d) Requirements relating to administration and other matters

(1) Administration

(A) In general

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5) of this section).

(B) Required notices

If a change occurs in--

- (i) the persons with an ownership or control interest (as defined in [section 1320a-3\(a\)\(3\)](#) of this title) in the facility,
- (ii) the persons who are officers, directors, agents, or managing employees (as defined in [section 1320a-5\(b\)](#) of this title) of the facility,
- (iii) the corporation, association, or other company responsible for the management of the facility, or
- (iv) the individual who is the administrator or director of nursing of the facility,

the nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

(C) Nursing facility administrator

The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4) of this section.

(2) Licensing and life safety code

(A) Licensing

A nursing facility must be licensed under applicable State and local law.

(B) Life Safety Code

A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that--

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

(3) Sanitary and infection control and physical environment

A nursing facility must--

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) Miscellaneous

(A) Compliance with Federal, State, and local laws and professional standards

A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of [section 1320a-3](#) of this title) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) Other

A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) State requirements relating to nursing facility requirements

As a condition of approval of its plan under this subchapter, a State must provide for the following:

(1) Specification and review of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs

The State must--

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency

evaluation programs, that the State approves for purposes of subsection (b)(5) of this section and that meet the requirements established under subsection (f)(2) of this section, and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii) of this section.

The failure of the Secretary to establish requirements under subsection (f)(2) of this section shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry

(A) In general

By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) of this section or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) Information in registry

The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of this section of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges

A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3) of this section, for hearing appeals on transfers and discharges of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

(4) Nursing facility administrator standards

By not later than July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under subsection (f)(4) of this section respecting the qualification of administrators of nursing facilities.

(5) Specification of resident assessment instrument

Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii) of this section. Such instrument shall be--

(A) one of the instruments designated under subsection (f)(6)(B) of this section, or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A) of this section.

(6) Notice of medicaid rights

Each State, as a condition of approval of its plan under this subchapter, effective April 1, 1988, must develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this subchapter.

(7) State requirements for preadmission screening and resident review

(A) Preadmission screening

(i) In general

Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8) of this section) described in subsection (b)(3)(F) of this section for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (f)(8) of this section shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).

(ii) Clarification with respect to certain readmissions

The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(iii) Exception for certain hospital discharges

The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual--

(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

(B) State requirement for resident review

(i) For mentally ill residents

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) of this section and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)--

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in [section 1396d\(h\)](#) of this title) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

(II) whether or not the resident requires specialized services for mental illness.

(ii) For mentally retarded residents

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8) of this section)--

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under [section 1396d\(d\)](#) of this title; and

(II) whether or not the resident requires specialized services for mental retardation.

(iii) Review required upon change in resident's condition

A review and determination under clause (i) or (ii) must be conducted promptly after a nursing facility has notified the State mental health authority or State mental retardation or developmental disability authority, as applicable, under subsection (b)(3)(E) of this section with respect to a mentally ill or mentally retarded resident, that there has been a significant change in the resident's physical or mental condition.

(iv) Prohibition of delegation

A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(C) Response to preadmission screening and resident review

As of April 1, 1990, the State must meet the following requirements:

(i) Long-term residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers--

(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resi-

dent,

(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

A State shall not be denied payment under this subchapter for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

(ii) Other residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers--

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2) of this section,

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

(iii) Residents not requiring nursing facility services and not requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require specialized services for mental illness or mental retardation, the State must--

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2) of this section, and

(II) prepare and orient the resident for such discharge.

(iv) Annual report

Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).

(D) Denial of payment

(i) For failure to conduct preadmission screening or review

No payment may be made under [section 1996b\(a\)](#) of this title with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) of this section or subparagraph (B) but for whom the determination is not made.

(ii) For certain residents not requiring nursing facility level of services

No payment may be made under [section 1396b\(a\)](#) of this title with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.

(E) Permitting alternative disposition plans

With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require specialized services for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirements of subparagraphs (A) through (C) of this paragraph if, before April 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C). The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.

(F) Appeals procedures

Each State, as a condition of approval of its plan under this subchapter, effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

(G) Definitions

In this paragraph and in subsection (b)(3)(F) of this section:

(i) An individual is considered to be “mentally ill” if the individual has serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health) and does not have a primary diagnosis of dementia (including Alzheimer’s disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness.

(ii) An individual is considered to be “mentally retarded” if the individual is mentally retarded or a person with a related condition (as described in [section 1396d\(d\)](#) of this title).

(iii) The term “specialized services” has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4) of this section.

(f) Responsibilities of Secretary relating to nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing

facilities under State plans approved under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) Requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs

(A) In general

For purposes of subsections (b)(5) and (e)(1)(A) of this section, the Secretary shall establish, by not later than September 1, 1988--

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that--

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

(B) Approval of certain programs

Such requirements--

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on December 22, 1987;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) of this section if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D), shall prohibit approval of such a program--

(I) offered by or in a nursing facility which, within the previous 2 years--

(a) has operated under a waiver under subsection (b)(4)(C)(ii) of this section that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) of this section for a period in excess of 48 hours during a week;

(b) has been subject to an extended (or partial extended) survey under [section 1395i-3\(g\)\(2\)\(B\)\(i\)](#) of this title or subsection (g)(2)(B)(i) of this section; or

(c) has been assessed a civil money penalty described in [section 1395i-3\(h\)\(2\)\(B\)\(ii\)](#) of this title or subsection (h)(2)(A)(ii) of this section of not less than \$5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i) of this section, clauses (i), (iii), or (iv) of subsection (h)(2)(A) of this section, [clauses \(i\)](#) or [\(iii\) of section 1395i-3\(h\)\(2\)\(B\)](#) of this title, or [section 1395i-3\(h\)\(4\)](#) of this title, or

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the nursing facility.

(C) Waiver authorized

Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of subchapter XVIII of this chapter) in a State if the State--

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

(iii) provides notice of such determination and assurances to the State long-term care ombudsman.

(D) Waiver of disapproval of nurse-aide training programs

Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.

(3) Federal guidelines for State appeals process for transfers and discharges

For purposes of subsections (c)(2)(B)(iii) and (e)(3) of this section, by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) of this section must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from nursing facilities.

(4) Secretarial standards qualification of administrators

For purposes of subsections (d)(1)(C) and (e)(4) of this section, the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

(5) Criteria for administration

The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) of this section with respect to--

- (A) its governing body and management,
- (B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,
- (C) disaster preparedness,
- (D) direction of medical care by a physician,
- (E) laboratory and radiological services,
- (F) clinical records, and
- (G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments

The Secretary shall--

- (A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3) of this section, and establish guidelines for utilization of the data set; and
- (B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) of this section for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii) of this section.

(7) List of items and services furnished in nursing facilities not chargeable to the personal funds of a resident

(A) Regulations required

Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after December 22, 1987, that

define those costs which may be charged to the personal funds of residents in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this subchapter and those costs which are to be included in the payment amount under this subchapter for nursing facility services.

(B) Rule if failure to publish regulations

If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services under this subchapter, for purposes of [section 1396a\(a\)\(28\)\(B\)](#) of this title, the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this subchapter) include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Federal minimum criteria and monitoring for preadmission screening and resident review

(A) Minimum criteria

The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (b)(3)(F) and (e)(7)(B) of this section and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

(B) Monitoring compliance

The Secretary shall review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) of this section (relating to discharge and placement for active treatment of certain residents).

(9) Criteria for monitoring State waivers

The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances and granting waivers pursuant to subsection (b)(4)(C)(ii) of this section.

(g) Survey and certification process

(1) State and Federal responsibility

(A) In general

Under each State plan under this subchapter, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d) of this section. The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) Removal of name from nurse aide registry

(i) In general

In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that--

(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

(II) the neglect involved in the original finding was a singular occurrence.

(ii) Timing of determination

In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) Construction

The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) Surveys

(A) Annual standard survey

(i) In general

Each nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed \$2,000. The provisions of [section 1320a-7a](#) of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title. The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents

Each standard survey shall include, for a case-mix stratified sample of residents--

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) of this section and an audit of the residents' assessments under subsection (b)(3) of this section to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c) of this section.

(iii) Frequency

(I) In general

Each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) Extended surveys

(i) In general

Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) Timing

The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) Contents

In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d) of this section. Such review shall include an expansion of the size of the sample

of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) Construction

Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) of this section on the basis of findings in a standard survey.

(C) Survey protocol

Standard and extended surveys shall be conducted--

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys

Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) Survey teams

(i) In general

Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) Prohibition of conflicts of interest

A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d) of this section, or who has a personal or familial financial interest in the facility being surveyed.

(iii) Training

The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) Validation surveys**(A) In general**

The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) Scope

With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of nursing facilities surveyed by the State in the year, but in no case less than 5 nursing facilities in the State.

(C) Reduction in administrative costs for substandard performance

If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey teams in the State and shall provide for a reduction of the payment otherwise made to the State under [section 1396b\(a\)\(2\)\(D\)](#) of this title with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d) of this section. A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under [section 1316](#) of this title in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under [section 1316\(a\)\(1\)](#) of this title.

(D) Special surveys of compliance

Where the Secretary has reason to question the compliance of a nursing facility with any of the requirements of subsections (b), (c), and (d) of this section, the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the nursing facility meets such requirements.

(4) Investigation of complaints and monitoring nursing facility compliance

Each State shall maintain procedures and adequate staff to--

(A) investigate complaints of violations of requirements by nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d) of this section, if--

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.

(5) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public--

(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this subchapter or under subchapter XVIII of this chapter,

(iii) copies of statements of ownership under [section 1320a-3](#) of this title, and

(iv) information disclosed under [section 1320a-5](#) of this title.

(B) Notice to ombudsman

Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [[42 U.S.C.A. § 3021 et seq.](#) or [§ 3058 et seq.](#)] in accordance with section 712 of the Act [[42 U.S.C.A. § 3058g](#)]) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d) of this section, or of any adverse action taken against a nursing facility under paragraphs [\[FNI\]](#) (1), (2), or (3) of subsection (h) of this section, with respect to a nursing facility in the State.

(C) Notice to physicians and nursing facility administrator licensing board

If a State finds that a nursing facility has provided substandard quality of care, the State shall notify--

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) any State board responsible for the licensing of the nursing facility administrator of the facility.

(D) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under [section 1396b\(q\)](#) of this title) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(h) Enforcement process

(1) In general

If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) of this section or otherwise, that a nursing facility no longer meets a requirement of subsection (b), (c), or (d) of this section, and further finds that the facility's deficiencies--

(A) immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its residents, the State may--

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Specified remedies

(A) Listing

Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d) of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i) of this section) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while--

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d) of this section.

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d) of this section.

(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as directed plans of correction.

(B) Deadline and guidance

(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

(C) Assuring prompt compliance

If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d) of this section, within 3 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) Repeated noncompliance

In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2) of this section, has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)--

(i) impose the remedy described in subparagraph (A)(i), and

(ii) monitor the facility under subsection (g)(4)(B) of this section,

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d) of this section, and that it will remain in compliance with such requirements.

(E) Funding

The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of [section 1396b\(a\)\(7\)](#) of this title, to be necessary for the proper and efficient administration of the State plan.

(F) Incentives for high quality care

In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this subchapter. For purposes of [section 1396b\(a\)\(7\)](#) of this title, proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this subchapter.

(3) Secretarial authority

(A) For State nursing facilities

With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).

(B) Other nursing facilities

With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e) of this section, and further finds that the facility's deficiencies--

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(C) Specified remedies

The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties

The Secretary may impose a civil money penalty in an amount not to exceed \$10,000 for each day of noncompliance. The provisions of [section 1320a-7a](#) of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(iii) Appointment of temporary management

In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while--

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d) of this section.

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d) of this section.

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(D) Continuation of payments pending remediation

The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d) of this section, if--

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility, and

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(4) Effective period of denial of payment

A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d) of this section.

(5) Immediate termination of participation for facility where State or Secretary finds noncompliance and immediate jeopardy

If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d) of this section, and finds that the failure immediately jeopardizes the health or safety of its residents, the State or the Secretary, respectively [\[FN2\]](#) shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2) of this section.

(6) Special rules where State and Secretary do not agree on finding of noncompliance

(A) State finding of noncompliance and no Secretarial finding of noncompliance

If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d) of this section, but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) Secretarial finding of noncompliance and no State finding of noncompliance

If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d) of this section, and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary--

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) Special rules for timing of termination of participation where remedies overlap

If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d) of this section, and neither finds that the failure immediately jeopardizes the health or safety of its residents--

(A)(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

(B)(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary

shall apply.

(8) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII of this chapter.

(9) Sharing of information

Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XVIII of this chapter, including investigations by State medicaid fraud control units.

(i) Construction

Where requirements or obligations under this section are identical to those provided under [section 1395i-3](#) of this title, the fulfillment of those requirements or obligations under [section 1395i-3](#) of this title shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

[\[FN1\]](#) So in original. Probably should be “paragraph”.

[\[FN2\]](#) So in original. Probably should be followed by a comma.

§ 1396r-1. Presumptive eligibility for pregnant women

(a) Ambulatory prenatal care

A State plan approved under [section 1396a](#) of this title may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

(b) Definitions

For purposes of this section--

(1) the term “presumptive eligibility period” means, with respect to a pregnant woman, the period that--

(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of--

(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, or

(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day; and

(2) the term “qualified provider” means any provider that--

(A) is eligible for payments under a State plan approved under this subchapter,

(B) provides services of the type described in [subparagraph \(A\)](#) or [\(B\) of section 1396d\(a\)\(2\)](#) of this title or in [section 1396d\(a\)\(9\)](#) of this title,

(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

(D)(i) receives funds under--

(I) [section 254b](#) or [254c](#) of this title,

(II) subchapter V of this chapter, or

(III) title V of the Indian Health Care Improvement Act [[25 U.S.C.A. § 1651 et seq.](#)];

(ii) participates in a program established under--

(I) [section 1786](#) of this title, or

(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973;

(iii) participates in a State perinatal program; or

(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act ([Public Law 93-638](#)) [[25 U.S.C.A. § 450f et seq.](#)].

The term “qualified provider” also includes a qualified entity, as defined in [section 1396r-1a\(b\)\(3\)](#) of this title.

(c) Duties of State agency, qualified providers, and presumptively eligible pregnant women

(1) The State agency shall provide qualified providers with--

(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

(B) information on how to assist such women in completing and filing such forms.

(2) A qualified provider that determines under subsection (b)(1)(A) of this section that a pregnant woman is presumptively eligible for medical assistance under a State plan shall--

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the woman at the time the determination is made that she is required to make application for medical assistance

under the State plan by no later than the last day of the month following the month during which the determination is made.

(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan by no later than the last day of the month following the month during which the determination is made which application may be the application used for the receipt of medical assistance by individuals described in [section 1396a\(1\)\(1\)\(A\)](#) of this title.

(d) Ambulatory prenatal care as medical assistance

Notwithstanding any other provision of this subchapter, ambulatory prenatal care that--

(1) is furnished to a pregnant woman--

(A) during a presumptive eligibility period,

(B) by a provider that is eligible for payments under the State plan; and

(2) is included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of [section 1396b](#) of this title.

§ 1396r-1a. Presumptive eligibility for children

(a) A State plan approved under [section 1396a](#) of this title may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

(b) For purposes of this section:

(1) The term “child” means an individual under 19 years of age.

(2) The term “presumptive eligibility period” means, with respect to a child, the period that--

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of--

(i) the day on which a determination is made with respect to the eligibility of the child for medical assistance under the State plan, or

(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(3)(A) Subject to subparagraph (B), the term “qualified entity” means any entity that--

(i)(I) is eligible for payments under a State plan approved under this subchapter and provides items and services described in subsection (a) of this section,

(II) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act ([42 U.S.C. 9831 et seq.](#)), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 ([42 U.S.C. 9858 et seq.](#)), eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under [section 1786](#) of this title [\[FNI\]](#) eligibility of a child for medical assistance under the State plan under this subchapter, or eligibility of a child for child health assistance under the program funded under subchapter XXI of this chapter,

(III) is an elementary school or secondary school, as such terms are defined in [section 8801 of Title 20](#), an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State or tribal child support enforcement agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State or tribal office or entity involved in enrollment in the program under this subchapter, under part A of subchapter IV of this chapter, under subchapter XXI of this chapter, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under Section 8 or any other section of the United States Housing Act of 1937 ([42 U.S.C. 1437 et seq.](#)) or under the Native American Housing Assistance and Self-Determination Act of 1996 ([25 U.S.C. 4101 et seq.](#)), or

(IV) any other entity the State so deems, as approved by the Secretary; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (2).

(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c)(1) The State agency shall provide qualified entities with--

(A) such forms as are necessary for an application to be made on behalf of a child for medical assistance under the State plan, and

(B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

(2) A qualified entity that determines under subsection (b)(2) of this section that a child is presumptively eligible for medical assistance under a State plan shall--

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in [section 1396a\(1\)\(1\)](#) of this title.

(d) Notwithstanding any other provision of this subchapter, medical assistance for items and services described in subsec-

tion (a) of this section that--

(1) are furnished to a child--

(A) during a presumptive eligibility period,

(B) by an entity that is eligible for payments under the State plan; and

(2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of [section 1396b](#) of this section.

[FN1]So in original. A comma probably should appear here.

§ 1396r-1b. Presumptive eligibility for certain breast or cervical cancer patients

(a) State option

A State plan approved under [section 1396a](#) of this title may provide for making medical assistance available to an individual described in [section 1396a\(aa\)](#) of this title (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

(b) Definitions

For purposes of this section:

(1) Presumptive eligibility period

The term “presumptive eligibility period” means, with respect to an individual described in subsection (a), the period that--

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in [section 1396a\(aa\)](#) of this title; and

(B) ends with (and includes) the earlier of--

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) Qualified entity

(A) In general

Subject to subparagraph (B), the term “qualified entity” means any entity that--

(i) is eligible for payments under a State plan approved under this subchapter; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) Regulations

The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) Rule of construction

Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c) Administration

(1) In general

The State agency shall provide qualified entities with--

(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

(B) information on how to assist such individuals in completing and filing such forms.

(2) Notification requirements

A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall--

(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) Application for medical assistance

In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

(d) Payment

Notwithstanding any other provision of this subchapter, medical assistance that--

(1) is furnished to an individual described in subsection (a)--

(A) during a presumptive eligibility period;

(B) by a [\[FN1\]](#) entity that is eligible for payments under the State plan; and

(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of [section 1396d\(b\)](#) of this title.

[\[FN1\]](#) So in original. Probably should be “an”.

§ 1396r-2. Information concerning sanctions taken by State licensing authorities against health care practitioners and providers

(a) Information reporting requirement

The requirement referred to in [section 1396a\(a\)\(49\)](#) of this title is that the State must provide for the following:

(1) Information reporting system

The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities:

(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

(D) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity.

(2) Access to documents

The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this chapter.

(b) Form of information

The information described in subsection (a)(1) of this section shall be provided to the Secretary (or to an appropriate private or public agency, under suitable arrangements made by the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of information) in such a form and manner as the Secretary determines to be appropriate

in order to provide for activities of the Secretary under this chapter and in order to provide, directly or through suitable arrangements made by the Secretary, information--

- (1) to agencies administering Federal health care programs, including private entities administering such programs under contract,
- (2) to licensing authorities described in subsection (a)(1) of this section,
- (3) to State agencies administering or supervising the administration of State health care programs (as defined in [section 1320a-7\(h\)](#) of this title),
- (4) to utilization and quality control peer review organizations described in part B of subchapter XI of this chapter and to appropriate entities with contracts under [section 1320c-3\(a\)\(4\)\(C\)](#) of this title with respect to eligible organizations reviewed under the contracts,
- (5) to State medicaid fraud control units (as defined in [section 1396b\(q\)](#) of this title),
- (6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986 [[42 U.S.C.A. § 11151](#)]), with respect to physicians or other licensed health care practitioners that have entered (or may be entering) into an employment or affiliation relationship with, or have applied for clinical privileges or appointments to the medical staff of, such hospitals or other health care entities (and such information shall be deemed to be disclosed pursuant to [section 427](#) [[42 U.S.C.A. § 11137](#)] of, and be subject to the provisions of, that Act [[42 U.S.C.A. § 11101 et seq.](#)]),
- (7) to the Attorney General and such other law enforcement officials as the Secretary deems appropriate, and
- (8) upon request, to the Comptroller General,

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

(c) Confidentiality of information provided

The Secretary shall provide for suitable safeguards for the confidentiality of the information furnished under subsection (a) of this section. Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.

(d) Appropriate coordination

The Secretary shall provide for the maximum appropriate coordination in the implementation of subsection (a) of this section and section 422 of the Health Care Quality Improvement Act of 1986 [[42 U.S.C.A. § 11132](#)].

[§ 1396r-3. Correction and reduction plans for intermediate care facilities for mentally retarded](#)

(a) Written plans to remedy substantial deficiencies; time for submission

If the Secretary finds that an intermediate care facility for the mentally retarded has substantial deficiencies which do not pose an immediate threat to the health and safety of residents (including failure to provide active treatment), the State may elect, subject to the limitations in this section, to--

(1) submit, within the number of days specified by the Secretary in regulations which apply to submission of compliance plans with respect to deficiencies of such type, a written plan of correction which details the extent of the facility's current compliance with the standards promulgated by the Secretary, including all deficiencies identified during a validation survey, and which provides for a timetable for completion of necessary steps to correct all staffing deficiencies within 6 months, and a timetable for rectifying all physical plant deficiencies within 6 months; or

(2) submit, within a time period consisting of the number of days specified for submissions under paragraph (1) plus 35 days, a written plan for permanently reducing the number of certified beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct parts thereof) to be vacated and any staffing deficiencies to be corrected (hereinafter in this section referred to as a "reduction plan").

(b) Conditions for approval of reduction plans

As conditions of approval of any reduction plan submitted pursuant to subsection (a)(2) of this section, the State must--

(1) provide for a hearing to be held at the affected facility at least 35 days prior to submission of the reduction plan, with reasonable notice thereof to the staff and residents of the facility, responsible members of the residents' families, and the general public;

(2) demonstrate that the State has successfully provided home and community services similar to the services proposed to be provided under the reduction plan for similar individuals eligible for medical assistance; and

(3) provide assurances that the requirements of subsection (c) of this section shall be met with respect to the reduction plan.

(c) Contents of reduction plan

The reduction plan must--

(1) identify the number and service needs of existing facility residents to be provided home or community services and the timetable for providing such services, in 6 month intervals, within the 36-month period;

(2) describe the methods to be used to select such residents for home and community services and to develop the alternative home and community services to meet their needs effectively;

(3) describe the necessary safeguards that will be applied to protect the health and welfare of the former residents of the facility who are to receive home or community services, including adequate standards for consumer and provider participation and assurances that applicable State licensure and applicable State and Federal certification requirements will be met in providing such home or community services;

(4) provide that residents of the affected facility who are eligible for medical assistance while in the facility shall, at their option, be placed in another setting (or another part of the affected facility) so as to retain their eligibility for medical assistance;

(5) specify the actions which will be taken to protect the health and safety of, and to provide active treatment for, the residents who remain in the affected facility while the reduction plan is in effect;

(6) provide that the ratio of qualified staff to residents at the affected facility (or the part thereof) which is subject to the reduction plan will be the higher of--

(A) the ratio which the Secretary determines is necessary in order to assure the health and safety of the residents of such facility (or part thereof); or

(B) the ratio which was in effect at the time that the finding of substantial deficiencies (referred to in subsection (a) of this section) was made; and

(7) provide for the protection of the interests of employees affected by actions under the reduction plan, including--

(A) arrangements to preserve employee rights and benefits;

(B) training and retraining of such employees where necessary;

(C) redeployment of such employees to community settings under the reduction plan; and

(D) making maximum efforts to guarantee the employment of such employees (but this requirement shall not be construed to guarantee the employment of any employee).

(d) Notice and comment; approval of more than 15 reduction plans in any fiscal year; corrections costing \$2,000,000 or more

(1) The Secretary must provide for a period of not less than 30 days after the submission of a reduction plan by a State, during which comments on such reduction plan may be submitted to the Secretary, before the Secretary approves or disapproves such reduction plan.

(2) If the Secretary approves more than 15 reduction plans under this section in any fiscal year, any reduction plans approved in addition to the first 15 such plans approved, must be for a facility (or part thereof) for which the costs of correcting the substantial deficiencies (referred to in subsection (a) of this section) are \$2,000,000 or greater (as demonstrated by the State to the satisfaction of the Secretary).

(e) Termination of provider agreements; disallowance of percentage amounts for purposes of Federal financial participation

(1) If the Secretary, at the conclusion of the 6-month plan of correction described in subsection (a)(1) of this section, determines that the State has substantially failed to correct the deficiencies described in subsection (a) of this section, the Secretary may terminate the facility's provider agreement in accordance with the provisions of [section 1396i\(b\)](#) of this title.

(2) In the case of a reduction plan described in subsection (a)(2) of this section, if the Secretary determines, at the conclusion of the initial 6-month period or any 6-month interval thereafter, that the State has substantially failed to meet the requirements of subsection (c) of this section, the Secretary shall--

(A) terminate the facility's provider agreement in accordance with the provisions of [section 1396i\(b\)](#) of this title; or

(B) if the State has failed to meet such requirements despite good faith efforts, disallow, for purposes of Federal financial participation, an amount equal to 5 percent of the cost of care for all eligible individuals in the facility for each month for which the State fails to meet such requirements.

(f) Applicability of section limited to plans approved by January 1, 1990

The provisions of this section shall apply only to plans of correction and reduction plans approved by the Secretary by

January 1, 1990.

§ 1396r-4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of [section 1396a\(a\)\(13\)\(A\)\(iv\)](#) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that--

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) of this section which meets the requirements of subsection (d) of this section), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) of this section.

(2)(A) In order to be considered to have met such requirement of [section 1396a\(a\)\(13\)\(A\)](#) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c) of this section, effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of [section 1396a\(a\)\(13\)\(A\)](#) of this title as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f) of this section, effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this subchapter provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of [section 1396a\(a\)\(13\)\(A\)](#) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this subchapter shall not be considered to meet the requirements of [section 1396a\(a\)\(13\)\(A\)\(iv\)](#) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients (including such patients who receive benefits through a managed care entity) served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under [section 1396n\(b\)\(4\)](#) of this title.

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1) of this section, a hospital which meets the requirements of subsection (d) of this section is deemed to be a disproportionate share hospital if--

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of--

(A) the fraction (expressed as a percentage)--

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this subchapter (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)--

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this subchapter).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to [section 1396b\(w\)\(1\)\(A\)\(iii\)](#) of this title if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in [section 1396b\(w\)\(4\)](#) of this title.

(c) Payment adjustment

Subject to subsections (f) and (g) of this section, in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either--

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in [section 1395ww\(a\)\(4\)](#) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under [section 1395ww\(d\)\(5\)\(F\)\(iv\)](#) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1) of this section) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2) of this section) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in paragraph [\[FN1\]](#) (b)(3) of this section); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that--

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients,

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a) of this section, the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) of this section (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in [section 1395ww\(d\)\(5\)\(F\)\(vi\)](#) of this title) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) of this section to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) Requirements to qualify as disproportionate share hospital

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital--

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of December 22, 1987.

(B) In the case of a hospital located in a rural area (as defined for purposes of [section 1395ww](#) of this title), in paragraph (1) the term “obstetrician” includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2) of this section) of not less than 1 percent.

(e) Special rule

(1) A State plan shall be considered to meet the requirement of [section 1396a\(a\)\(13\)\(A\)\(iv\)](#) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) of this section if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and (C) the plan meets the requirement of subsection (d)(3) of this section and such payment adjustments are made consistent with the last sentence of subsection (c) of this section.

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a statewide basis, beginning on July 1, 1988--

(A) the requirements of subsections (b) and (c) of this section (other than the last sentence of subsection (c) of this section) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied,

(B) subsection (d)(2)(B) of this section shall apply to hospitals located in urban areas, as well as in rural areas,

(C) subsection (d)(3) of this section shall apply, and

(D) subsection (g) of this section shall apply.

(f) Limitation on Federal financial participation

(1) In general

Payment under [section 1396b\(a\)](#) of this title shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as “DSH”) allotment for the State for the fiscal year, as specified in paragraphs (2) and (3).

(2) State DSH allotments for fiscal years 1998 through 2002

Subject to paragraph (4), the DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year 2002 is determined in accordance with the following table:

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1,085	1,068	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	49	49	49
Florida	207	203	197	188	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	201	197	191	181	171
Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Kentucky	137	134	130	123	116
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	16	16	33	33	33
Mississippi	143	141	136	129	122
Missouri	436	423	379	379	379
Montana	0.2	0.2	0.2	0.2	0.2
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	5	9	9	9
New York	1,512	1,482	1,436	1,361	1,285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	374	363	344	325
Oklahoma	16	16	16	16	16

Oregon	20	20	20	20	20
Pennsylvania	529	518	502	476	449
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	66	63	59
Washington	174	171	166	157	148
West Virginia	64	63	61	58	54
Wisconsin	7	7	7	7	7
Wyoming	0	0	0.1	0.1	0.1

(3) State DSH allotments for fiscal year 2003 and thereafter

(A) In general

Except as provided in paragraph (6) and subparagraph (E), the DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraphs (B) and (C) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(B) Limitation

The DSH allotment for a State shall not be increased under subparagraph (A) for a fiscal year to the extent that such an increase would result in the DSH allotment for the year exceeding the greater of--

- (i) the DSH allotment for the previous year, or
- (ii) 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

(C) Special, temporary increase in allotments on a one-time, non-cumulative basis

The DSH allotment for any State (other than a State with a DSH allotment determined under paragraph (5))--

- (i) for fiscal year 2004 is equal to 116 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and
- (ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the DSH allotment for the State for the previous fiscal year increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(D) Fiscal year specified

For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.

(E) Temporary increase in allotments during recession

(i) In general

Subject to clause (ii), the DSH allotment for any State--

(I) for fiscal year 2009 is equal to 102.5 percent of the DSH allotment that would be determined under this paragraph for the State for fiscal year 2009 without application of this subparagraph, notwithstanding subparagraphs (B) and (C);

(II) for fiscal year 2010 is equal to 102.5 percent of the DSH allotment for the State for fiscal year 2009, as determined under subclause (I); and

(III) for each succeeding fiscal year is equal to the DSH allotment for the State under this paragraph determined without applying subclauses (I) and (II).

(ii) Application

Clause (i) shall not apply to a State for a year in the case that the DSH allotment for such State for such year under this paragraph determined without applying clause (i) would grow higher than the DSH allotment specified under clause (i) for the State for such year.

(4) Special rule for fiscal years 2001 and 2002

(A) In general

Notwithstanding paragraph (2), the DSH allotment for any State for--

(i) fiscal year 2001, shall be the DSH allotment determined under paragraph (2) for fiscal year 2000 increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2000; and

(ii) fiscal year 2002, shall be the DSH allotment determined under clause (i) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2001.

(B) Limitation

Subparagraph (B) of paragraph (3) shall apply to subparagraph (A) of this paragraph in the same manner as that subparagraph (B) applies to paragraph (3)(A).

(C) No application to allotments after fiscal year 2002

The DSH allotment for any State for fiscal year 2003 or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotments determined under subparagraph (A) of this paragraph.

(5) Special rule for low DSH States

(A) For fiscal years 2001 through 2003 for extremely low DSH States

In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is greater than 0 but less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year. In subsequent fiscal years before fiscal year 2004, such increased allotment is subject to an increase for inflation as provided in paragraph (3)(A).

(B) For fiscal year 2004 and subsequent fiscal years

In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to--

- (i) fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent;
- (ii) each succeeding fiscal year before fiscal year 2009 shall be the DSH allotment for the State for the previous fiscal year increased by 16 percent; and
- (iii) fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A).

(6) Allotment adjustments for fiscal years 2007 through 2011 and the first calendar quarter of fiscal year 2012

(A) Tennessee

(i) In general

Only with respect to fiscal year 2007, the DSH allotment for Tennessee for such fiscal year, notwithstanding the table set forth in paragraph (2) or the terms of the TennCare Demonstration Project in effect for the State, shall be the greater of--

(I) the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for the demonstration year ending in 2006 that is reflected in the budget neutrality provision of the TennCare Demonstration Project; and

(II) \$280,000,000.

Only with respect to fiscal years 2008, 2009, 2010, and 2011, the DSH allotment for Tennessee for the fiscal year, notwithstanding such table or terms, shall be the amount specified in the previous sentence for fiscal year

2007. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be 1/4 of the amount specified in the first sentence for fiscal year 2007.

(ii) Limitation on amount of payment adjustments eligible for Federal financial participation

Payment under [section 1396b\(a\)](#) of this title shall not be made to Tennessee with respect to the aggregate amount of any payment adjustments made under this section for hospitals in the State for fiscal year 2007, 2008, 2009, 2010, 2011, or for period in fiscal year 2012 described in clause (i) that is in excess of 30 percent of the DSH allotment for the State for such fiscal year or period determined pursuant to clause (i).

(iii) State plan amendment

The Secretary shall permit Tennessee to submit an amendment to its State plan under this subchapter that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals. For purposes of demonstrating budget neutrality under the TennCare Demonstration Project, payment adjustments made pursuant to a State plan amendment approved in accordance with this subparagraph shall be considered expenditures under such project.

(iv) Offset of Federal share of payment adjustments for fiscal years 2007 through 2011 and the first calendar quarter of fiscal year 2012 against essential access hospital supplemental pool payments under the TennCare demonstration project

(I) The total amount of Essential Access Hospital supplemental pool payments that may be made under the TennCare Demonstration Project for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) shall be reduced on a dollar for dollar basis by the amount of any payments made under [section 1396b\(a\)](#) of this title to Tennessee with respect to payment adjustments made under this section for hospitals in the State for such fiscal year or period.

(II) The sum of the total amount of payments made under [section 1396b\(a\)](#) of this title to Tennessee with respect to payment adjustments made under this section for hospitals in the State for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) and the total amount of Essential Access Hospital supplemental pool payments made under the TennCare Demonstration Project for such fiscal year or period shall not exceed the State's DSH allotment for such fiscal year or period established under clause (i).

(B) Hawaii

(i) In general

Only with respect to each of fiscal years 2007 through 2011, the DSH allotment for Hawaii for such fiscal year, notwithstanding the table set forth in paragraph (2), shall be \$10,000,000. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be \$2,500,000.

(ii) State plan amendment

The Secretary shall permit Hawaii to submit an amendment to its State plan under this subchapter that describes the

methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals.

(7) Definition of State

In this subsection, the term "State" means the 50 States and the District of Columbia.

(g) Limit on amount of payment to hospital

(1) Amount of adjustment subject to uncompensated costs

(A) In general

A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) of this section with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

(B) Limit to public hospitals during transition period

With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) Modifications for private hospitals

With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such hospitals as the Secretary considers appropriate.

(2) Additional amount during transition period for certain hospitals with high disproportionate share

(A) In general

In the case of a hospital with high disproportionate share (as defined in subparagraph (B)), a payment adjustment during a State fiscal year that begins before January 1, 1995, shall be considered consistent with subsection (c) of this section if the payment adjustment does not exceed 200 percent of the costs of furnishing hospital services described in paragraph (1)(A) during the year, but only if the Governor of the State certifies to the satisfaction of the Secretary that the hospital's applicable minimum amount is used for health services during the year. In determining the amount that is used for such services during a year, there shall be excluded any amounts received under the Public Health Service Act [[42 U.S.C.A. § 201 et seq.](#)], subchapter V of this chapter, subchapter XVIII of this chapter, or from third party payors (not including the State plan under this subchapter) that are used for providing such services during the year.

(B) Hospitals with high disproportionate share defined

In subparagraph (A), a hospital is a “hospital with high disproportionate share” if--

(i) the hospital is owned or operated by a State (or by an instrumentality or a unit of government within a State); and

(ii) the hospital--

(I) meets the requirement described in subsection (b)(1)(A) of this section, or

(II) has the largest number of inpatient days attributable to individuals entitled to benefits under the State plan of any hospital in such State for the previous State fiscal year.

(C) “Applicable minimum amount” defined

In subparagraph (A), the “applicable minimum amount” for a hospital for a fiscal year is equal to the difference between the amount of the hospital's payment adjustment for the fiscal year and the costs to the hospital of furnishing hospital services described in paragraph (1)(A) during the fiscal year.

(h) Limitation on certain State DSH expenditures

(1) In general

Payment under [section 1396b\(a\)](#) of this title shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year (beginning with fiscal year 1998) to institutions for mental diseases or other mental health facilities, to the extent the aggregate of such adjustments in the fiscal year exceeds the lesser of the following:

(A) 1995 IMD DSH payment adjustments

The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(B) Applicable percentage of 1995 total DSH payment allotment

The amount of such payment adjustments which are equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) of this section that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(2) Applicable percentage

(A) In general

For purposes of paragraph (1), the applicable percentage with respect to--

(i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or

(ii) a succeeding fiscal year is the lesser of the percentage determined under subparagraph (B) or the following percentage:

(I) For fiscal year 2001, 50 percent.

(II) For fiscal year 2002, 40 percent.

(III) For each succeeding fiscal year, 33 percent.

(B) 1995 percentage

The percentage determined under this subparagraph is the ratio (determined as a percentage) of--

(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) of this section that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to

(ii) the State 1995 DSH spending amount.

(C) State 1995 DSH spending amount

For purposes of subparagraph (B)(ii), the "State 1995 DSH spending amount", with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) of this section under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).

(i) Requirement for direct payment

(1) In general

No payment may be made under [section 1396b\(a\)\(1\)](#) of this title with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are enrolled with a managed care entity (as defined in [section 1396u-2\(a\)\(1\)\(B\)](#) of this title) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment--

(A) is made directly to the hospital by the State; and

(B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals.

(2) Exception for current arrangements

Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.

(j) Annual reports and other requirements regarding payment adjustments

With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under [section 1396b\(a\)\(1\)](#) of this title with respect to a payment adjustment made under this section, to do the following:

(1) Report

The State shall submit an annual report that includes the following:

(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

(2) Independent certified audit

The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

(B) Payments under this section to hospitals that comply with the requirements of subsection (g) of this section.

(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

(D) The State included all payments under this subchapter, including supplemental payments, in the calculation of such hospital-specific limits.

(E) The State has separately documented and retained a record of all of its costs under this subchapter, claimed expenditures under this subchapter, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.

[\[FN1\]](#) So in original. Probably should be “subsection”.

[§ 1396r-5. Treatment of income and resources for certain institutionalized spouses](#)

(a) Special treatment for institutionalized spouses

(1) Supersedes other provisions

In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1) of this section), the provisions of this section supersede any other provision of this subchapter (including [sections 1396a\(a\)\(17\)](#) and [1396a\(f\)](#) of this title) which is inconsistent with them.

(2) No comparable treatment required

Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of [section 1396a\(a\)](#) of this title, require such treatment for other individuals.

(3) Does not affect certain determinations

Except as this section specifically provides, this section does not apply to--

(A) the determination of what constitutes income or resources, or

(B) the methodology and standards for determining and evaluating income and resources.

(4) Application in certain States and territories

(A) Application in States operating under demonstration projects

In the case of any State which is providing medical assistance to its residents under a waiver granted under [section 1315](#) of this title, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(B) No application in commonwealths and territories

This section shall only apply to a State that is one of the 50 States or the District of Columbia.

(5) Application to individuals receiving services under PACE programs

This section applies to individuals receiving institutional or noninstitutional services under a PACE demonstration waiver program (as defined in [section 1396u-4\(a\)\(7\)](#) of this title) or under a PACE program under section 1936u-4 or 1395eee of this title.

(b) Rules for treatment of income

(1) Separate treatment of income

During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

(2) Attribution of income

In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d) of this section, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

(A) Non-trust property

Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides--

(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the in-

come shall be considered available only to that respective spouse;

(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(B) Trust property

In the case of a trust--

(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this subchapter (including [sections 1396a\(a\)\(17\)](#) and [1396p\(d\)](#) of this title), and

(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust--

(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(C) Property with no instrument

In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

(D) Rebutting ownership

The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

(c) Rules for treatment of resources

(1) Computation of spousal share at time of institutionalization

(A) Total joint resources

There shall be computed (as of the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse)--

- (i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and
- (ii) a spousal share which is equal to 1/2 of such total value.

(B) Assessment

At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this subchapter, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2) of this section.

(2) Attribution of resources at time of initial eligibility determination

In determining the resources of an institutionalized spouse at the time of application for benefits under this subchapter, regardless of any State laws relating to community property or the division of marital property--

- (A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and
- (B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) of this section (as of the time of application for benefits).

(3) Assignment of support rights

The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where--

- (A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;
- (B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or
- (C) the State determines that denial of eligibility would work an undue hardship.

(4) Separate treatment of resources after eligibility for benefits established

During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this subchapter, no resources of the community spouse

shall be deemed available to the institutionalized spouse.

(5) Resources defined

In this section, the term “resources” does not include--

(A) resources excluded under [subsection \(a\)](#) or [\(d\) of section 1382b](#) of this title, and

(B) resources that would be excluded under [section 1382b\(a\)\(2\)\(A\)](#) of this title but for the limitation on total value described in such section.

(d) Protecting income for community spouse

(1) Allowances to be offset from income of institutionalized spouse

After an institutionalized spouse is determined or redetermined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance (described in [section 1396a\(q\)\(1\)](#) of this title), in an amount not less than the amount specified in [section 1396a\(q\)\(2\)](#) of this title.

(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

(C) A family allowance, for each family member, equal to at least 1/3 of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse (as provided under [section 1396a\(r\)](#) of this title).

In subparagraph (C), the term “family member” only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(2) Community spouse monthly income allowance defined

In this section (except as provided in paragraph (5)), the “community spouse monthly income allowance” for a community spouse is an amount by which--

(A) except as provided in subsection (e) of this section, the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

(3) Establishment of minimum monthly maintenance needs allowance

(A) In general

Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (C), is equal to or exceeds--

(i) the applicable percent (described in subparagraph (B)) of 1/12 of the income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with [section 9902\(2\)](#) of this title) for a family unit of 2 members; plus

(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

(B) Applicable percent

For purposes of subparagraph (A)(i), the “applicable percent” described in this paragraph, effective as of--

(i) September 30, 1989, is 122 percent,

(ii) July 1, 1991, is 133 percent, and

(iii) July 1, 1992, is 150 percent.

(C) Cap on minimum monthly maintenance needs allowance

The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed \$1,500 (subject to adjustment under subsections (e) and (g) of this section).

(4) Excess shelter allowance defined

In paragraph (3)(A)(ii), the term “excess shelter allowance” means, for a community spouse, the amount by which the sum of--

(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

(B) the standard utility allowance (used by the State under [section 2014\(e\) of Title 7](#)) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

(5) Court ordered support

If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly

income so ordered.

(6) Application of “income first” rule to revision of community spouse resource allowance

For purposes of this subsection and subsections (c) and (e) of this section, a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.

(e) Notice and fair hearing

(1) Notice

Upon--

(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B) of this section), of the amount of any family allowances (described in subsection (d)(1)(C) of this section), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f) of this section, and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

(2) Fair hearing

(A) In general

If either the institutionalized spouse or the community spouse is dissatisfied with a determination of--

(i) the community spouse monthly income allowance;

(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B) of this section);

(iii) the computation of the spousal share of resources under subsection (c)(1) of this section;

(iv) the attribution of resources under subsection (c)(2) of this section; or

(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2) of this section);

such spouse is entitled to a fair hearing described in [section 1396a\(a\)\(3\)](#) of this title with respect to such determination if an application for benefits under this subchapter has been made on behalf of the institutionalized spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days

of the date of the request for the hearing.

(B) Revision of minimum monthly maintenance needs allowance

If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial distress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A) of this section, an amount adequate to provide such additional income as is necessary.

(C) Revision of community spouse resource allowance

If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2) of this section, an amount adequate to provide such a minimum monthly maintenance needs allowance.

(f) Permitting transfer of resources to community spouse

(1) In general

An institutionalized spouse may, without regard to [section 1396p\(c\)\(1\)](#) of this title, transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

(2) Community spouse resource allowance defined

In paragraph (1), the “community spouse resource allowance” for a community spouse is an amount (if any) by which--

(A) the greatest of--

(i) \$12,000 (subject to adjustment under subsection (g) of this section), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

(ii) the lesser of (I) the spousal share computed under subsection (c)(1) of this section, or (II) \$60,000 (subject to adjustment under subsection (g) of this section),

(iii) the amount established under subsection (e)(2) of this section; or

(iv) the amount transferred under a court order under paragraph (3);

exceeds

(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

(3) Transfers under court orders

If a court has entered an order against an institutionalized spouse for the support of the community spouse, [section 1396p](#) of this title shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse or a family member (as defined in subsection (d)(1) of this section).

(g) Indexing dollar amounts

For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) of this section shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

(h) Definitions

In this section:

(1) The term “institutionalized spouse” means an individual who--

(A) is in a medical institution or nursing facility or who (at the option of the State) is described in [section 1396a\(a\)\(10\)\(A\)\(ii\)\(VI\)](#) of this title, and

(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term “community spouse” means the spouse of an institutionalized spouse.

[§ 1396r-6. Extension of eligibility for medical assistance](#)

(a) Initial 6-month extension

(1) Requirement

(A) In general

Notwithstanding any other provision of this subchapter but subject to subparagraph (B) and paragraph (5), each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from, employment of the caretaker relative (as defined in subsection (e) of this section) or because of [section 602\(a\)\(8\)\(B\)\(ii\)\(II\)](#) of this title (providing for a time-limited earned income disregard), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this subchapter during the immediately succeeding 6-month period in accordance with this subsection.

(B) State option to waive requirement for 3 months before receipt of medical assistance

A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for

fewer than three months or that had applied for and was eligible for such aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.

(2) Notice of benefits

Each State, in the notice of termination of aid under part A of subchapter IV of this chapter sent to a family meeting the requirements of paragraph (1)--

(A) shall notify the family of its right to extended medical assistance under this subsection and include in the notice a description of the reporting requirement of subsection (b)(2)(B)(i) of this section and of the circumstances (described in paragraph (3)) under which such extension may be terminated; and

(B) shall include a card or other evidence of the family's entitlement to assistance under this subchapter for the period provided in this subsection.

(3) Termination of extension

(A) No dependent child

Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during such period) at the close of the first month in which the family ceases to include a child, whether or not the child is (or would if needy be) a dependent child under part A of subchapter IV of this chapter.

(B) Notice before termination

No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination.

(C) Continuation in certain cases until redetermination

With respect to a child who would cease to receive medical assistance because of subparagraph (A) but who may be eligible for assistance under the State plan because the child is described in [clause \(i\) of section 1396d\(a\)](#) of this title or [clause \(i\)\(IV\), \(i\)\(VI\), \(i\)\(VII\), or \(ii\)\(IX\) of section 1396a\(a\)\(10\)\(A\)](#) of this title, the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(4) Scope of coverage

(A) In general

Subject to subparagraph (B), during the 6-month extension period under this subsection, the amount, duration, and scope of medical assistance made available with respect to a family shall be the same as if the family were still receiving aid under the plan approved under part A of subchapter IV of this chapter.

(B) State Medicaid "wrap-around" option

A State, at its option, may pay a family's expenses for premiums, deductibles, coinsurance, and similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or by an employer of the absent parent of a dependent child. In the case of such coverage offered by an employer of the caretaker relative--

(i) the State may require the caretaker relative, as a condition of extension of coverage under this subsection for the caretaker and the caretaker's family, to make application for such employer coverage, but only if--

(I) the caretaker relative is not required to make financial contributions for such coverage (whether through payroll deduction, payment of deductibles, coinsurance, or similar costs, or otherwise), and

(II) the State provides, directly or otherwise, for payment of any of the premium amount, deductible, coinsurance, or similar expense that the employee is otherwise required to pay; and

(ii) the State shall treat the coverage under such an employer plan as a third party liability (under [section 1396a\(a\)\(25\)](#) of this title).

Payments for premiums, deductibles, coinsurance, and similar expenses under this subparagraph shall be considered, for purposes of [section 1396b\(a\)](#) of this title, to be payments for medical assistance.

(5) Option of 12-month initial eligibility period

A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.

(b) Additional 6-month extension

(1) Requirement

Notwithstanding any other provision of this subchapter but subject to paragraph (a)(5), each State plan approved under this subchapter shall provide that the State shall offer to each family, which has received assistance during the entire 6-month period under subsection (a) of this section and which meets the requirement of paragraph (2)(B)(i), in the last month of the period the option of extending coverage under this subsection for the succeeding 6-month period, subject to paragraph (3).

(2) Notice and reporting requirements

(A) Notices

(i) Notice during initial extension period of option and requirements

Each State, during the 3rd and 6th month of any extended assistance furnished to a family under subsection (a) of this section, shall notify the family of the family's option for additional extended assistance under this subsection. Each such notice shall include (I) in the 3rd month notice, a statement of the reporting requirement under subparagraph (B)(i), and, in the 6th month notice, a statement of the reporting requirement under subparagraph (B)(ii), (II) a statement as to whether any premiums are required for such additional extended assistance, and (III) a description of other out-of-pocket expenses, benefits, reporting and payment procedures, and any pre-existing condition limitations, waiting periods, or other coverage limitations imposed under any alternative coverage options offered under paragraph (4)(D). The 6th month notice under this subparagraph shall describe the amount of any premium required of a particular family for each of the first 3 months of additional extended assistance under this subsection.

(ii) Notice during additional extension period of reporting requirements and premiums

Each State, during the 3rd month of any additional extended assistance furnished to a family under this subsection,

shall notify the family of the reporting requirement under subparagraph (B)(ii) and a statement of the amount of any premium required for such extended assistance for the succeeding 3 months.

(B) Reporting requirements

(i) During initial extension period

Each State shall require (as a condition for additional extended assistance under this subsection) that a family receiving extended assistance under subsection (a) of this section report to the State, not later than the 21st day of the 4th month in the period of extended assistance under subsection (a) of this section, on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the first 3 months of that period. A State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis.

(ii) During additional extension period

Each State shall require that a family receiving extended assistance under this subsection report to the State, not later than the 21st day of the 1st month and of the 4th month in the period of additional extended assistance under this subsection, on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the 3 preceding months.

(iii) Clarification on frequency of reporting

A State may not require that a family receiving extended assistance under this subsection or subsection (a) report more frequently than as required under clause (i) or (ii).

(3) Termination of extension

(A) In general

Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during the period) as follows:

(i) No dependent child

The extension shall terminate at the close of the first month in which the family ceases to include a child, whether or not the child is (or would if needy be) a dependent child under part A of subchapter IV of this chapter.

(ii) Failure to pay any premium

If the family fails to pay any premium for a month under paragraph (5) by the 21st day of the following month, the extension shall terminate at the close of that following month, unless the family has established, to the satisfaction of the State, good cause for the failure to pay such premium on a timely basis.

(iii) Quarterly income reporting and test

The extension under this subsection shall terminate at the close of the 1st or 4th month of the 6-month period if--

(I) the family fails to report to the State, by the 21st day of such month, the information required under paragraph (2)(B)(ii), unless the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis;

(II) the caretaker relative had no earnings in one or more of the previous 3 months, unless such lack of any earnings was due to an involuntary loss of employment, illness, or other good cause, established to the satisfaction of the State; or

(III) the State determines that the family's average gross monthly earnings (less such costs for such child care as is necessary for the employment of the caretaker relative) during the immediately preceding 3-month period exceed 185 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with [section 9902\(2\)](#) of this title) applicable to a family of the size involved.

Information described in clause (iii)(I) shall be subject to the restrictions on use and disclosure of information provided under [section 602\(a\)\(9\)](#) of this title. Instead of terminating a family's extension under clause (iii)(I), a State, at its option, may provide for suspension of the extension until the month after the month in which the family reports information required under paragraph (2)(B)(ii), but only if the family's extension has not otherwise been terminated under subclause (II) or (III) of clause (iii). The State shall make determinations under clause (iii)(III) for a family each time a report under paragraph (2)(B)(ii) for the family is received.

(B) Notice before termination

No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination, which notice shall include (in the case of termination under subparagraph (A)(iii)(II), relating to no continued earnings) a description of how the family may reestablish eligibility for medical assistance under the State plan. No such termination shall be effective earlier than 10 days after the date of mailing of such notice.

(C) Continuation in certain cases until redetermination

(i) Dependent children

With respect to a child who would cease to receive medical assistance because of subparagraph (A)(i) but who may be eligible for assistance under the State plan because the child is described in [clause \(i\) of section 1396d\(a\)](#) of this title or [clause \(i\)\(IV\)](#), [\(i\)\(VI\)](#), [\(i\)\(VII\)](#), or [\(ii\)\(IX\) of section 1396a\(a\)\(10\)\(A\)](#) of this title, the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(ii) Medically needy

With respect to an individual who would cease to receive medical assistance because of clause (ii) or (iii) of subparagraph (A) but who may be eligible for assistance under the State plan because the individual is within a category of person for which medical assistance under the State plan is available under [section 1396a\(a\)\(10\)\(C\)](#) of this title (relating to medically needy individuals), the State may not discontinue such assistance under such subparagraph until the State has determined that the individual is not eligible for assistance under the plan.

(4) Coverage

(A) In general

During the extension period under this subsection--

(i) the State plan shall offer to each family medical assistance which (subject to subparagraphs (B) and (C)) is the same amount, duration, and scope as would be made available to the family if it were still receiving aid under the plan approved under part A of subchapter IV of this chapter; and

(ii) the State plan may offer alternative coverage described in subparagraph (D).

(B) Elimination of most non-acute care benefits

At a State's option and notwithstanding any other provision of this subchapter, a State may choose not to provide medical assistance under this subsection with respect to any (or all) of the items and services described in paragraphs (4)(A), (6), (7), (8), (11), (13), (14), (15), (16), (18), (20), and (21) of section 1396d(a) of this title.

(C) State medicaid "wrap-around" option

At a State's option, the State may elect to apply the option described in subsection (a)(4)(B) of this section (relating to "wrap-around" coverage) for families electing medical assistance under this subsection in the same manner as such option applies to families provided extended eligibility for medical assistance under subsection (a) of this section.

(D) Alternative assistance

At a State's option, the State may offer families a choice of health care coverage under one or more of the following, instead of the medical assistance otherwise made available under this subsection:

(i) Enrollment in family option of employer plan

Enrollment of the caretaker relative and dependent children in a family option of the group health plan offered to the caretaker relative.

(ii) Enrollment in family option of State employee plan

Enrollment of the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the State to State employees.

(iii) Enrollment in State uninsured plan

Enrollment of the caretaker relative and dependent children in a basic State health plan offered by the State to individuals in the State (or areas of the State) otherwise unable to obtain health insurance coverage.

(iv) Enrollment in medicaid managed care organization

Enrollment of the caretaker relative and dependent children in a medicaid managed care organization (as defined in [section 1396b\(m\)\(1\)\(A\)](#) of this title). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through a medicaid managed care organization in accordance with [section 1396b\(m\)](#) of this title and the applicable requirements

of [section 1396u-2](#) of this title.

If a State elects to offer an option to enroll a family under this subparagraph, the State shall pay any premiums and other costs for such enrollment imposed on the family and may pay deductibles and coinsurance imposed on the family. A State's payment of premiums for the enrollment of families under this subparagraph (not including any premiums otherwise payable by an employer and less the amount of premiums collected from such families under paragraph (5)) and payment of any deductibles and coinsurance shall be considered, for purposes of [section 1396b\(a\)\(1\)](#) of this title, to be payments for medical assistance.

(E) Prohibition on cost-sharing for maternity and preventive pediatric care

(i) In general

If a State offers any alternative option under subparagraph (D) for families, under each such option the State must assure that care described in clause (ii) is available without charge to the families through--

(I) payment of any deductibles, coinsurance, and other cost-sharing respecting such care, or

(II) providing coverage under the State plan for such care without any cost-sharing,

or any combination of such mechanisms.

(ii) Care described

The care described in this clause consists of--

(I) services related to pregnancy (including prenatal, delivery, and post partum services), and

(II) ambulatory preventive pediatric care (including ambulatory early and periodic screening, diagnosis, and treatment services under [section 1396d\(a\)\(4\)\(B\)](#) of this title) for each child who meets the age and date of birth requirements to be a qualified child under [section 1396d\(n\)\(2\)](#) of this title.

(5) Premium

(A) Permitted

Notwithstanding any other provision of this subchapter (including [section 1396o](#), of this title), a State may impose a premium for a family for additional extended coverage under this subsection for a premium payment period (as defined in subparagraph (D)(i)), but only if the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) for the premium base period exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with [section 9902\(2\)](#) of this title) applicable to a family of the size involved.

(B) Level may vary by option offered

The level of such premium may vary, for the same family, for each option offered by a State under paragraph (4)(D).

(C) Limit on premium

In no case may the amount of any premium under this paragraph for a family for a month in either of the premium payment periods described in subparagraph (D)(i) exceed 3 percent of the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) during the premium base period (as defined in subparagraph (D)(ii)).

(D) Definitions

In this paragraph:

(i) A “premium payment period” described in this clause is a 3-month period beginning with the 1st or 4th month of the 6-month additional extension period provided under this subsection.

(ii) The term “premium base period” means, with respect to a particular premium payment period, the period of 3 consecutive months the last of which is 4 months before the beginning of that premium payment period.

(c) Applicability in States and territories

(1) States operating under demonstration projects

In the case of any State which is providing medical assistance to its residents under a waiver granted under [section 1315\(a\)](#) of this title, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(2) Inapplicability in commonwealths and territories

The provisions of this section shall only apply to the 50 States and the District of Columbia.

(d) General disqualification for fraud

(1) Ineligibility for aid

This section shall not apply to an individual who is a member of a family which has received aid under part A of subchapter IV of this chapter if the State makes a finding that, at any time during the last 6 months in which the family was receiving such aid before otherwise being provided extended eligibility under this section, the individual was ineligible for such aid because of fraud.

(2) General disqualifications

For additional provisions relating to fraud and program abuse, see [sections 1320a-7](#), [1320a-7a](#), and [1320a-7b](#) of this title.

(e) “Caretaker relative” defined

In this section, the term “caretaker relative” has the meaning of such term as used in part A of subchapter IV of this chapter.

(f) Sunset

This section shall not apply with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter after December 31, 2010.

(g) Collection and reporting of participation information

(1) Collection of information from States

Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State's child health plan under subchapter XXI of this chapter. Such information shall be submitted at the same time and frequency in which other enrollment information under this subchapter is submitted to the Secretary.

(2) Annual reports to Congress

Using the information submitted under paragraph (1), the Secretary shall submit to Congress annual reports concerning enrollment and participation rates described in such paragraph.

[§ 1396r-7. Repealed. Pub. L. 105-33, Title IV, § 4713\(a\), 111 Stat. 509](#)

§ 1396r-8. Payment for covered outpatient drugs

(a) Requirement for rebate agreement

(1) In general

In order for payment to be available under [section 1396b\(a\)](#) of this title or under part B of subchapter XVIII for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b) of this section with the Secretary, on behalf of States (except that, the Secretary may authorize a State to enter directly into agreements with a manufacturer), and must meet the requirements of paragraph (5) (with respect to drugs purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992) and paragraph (6). Any agreement between a State and a manufacturer prior to April 1, 1991, shall be deemed to have been entered into on January 1, 1991, and payment to such manufacturer shall be retroactively calculated as if the agreement between the manufacturer and the State had been entered into on January 1, 1991. If a manufacturer has not entered into such an agreement before March 1, 1991, such an agreement, subsequently entered into, shall become effective as of the date on which the agreement is entered into or, at State option, on any date thereafter on or before the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.

(2) Effective date

Paragraph (1) shall first apply to drugs dispensed under this subchapter on or after January 1, 1991.

(3) Authorizing payment for drugs not covered under rebate agreements

Paragraph (1), and [section 1396b\(i\)\(10\)\(A\)](#) of this title, shall not apply to the dispensing of a single source drug or innovator multiple source drug if (A)(i) the State has made a determination that the availability of the drug is essential to the health of beneficiaries under the State plan for medical assistance; (ii) such drug has been given a rating of 1-A by the Food and Drug Administration; and (iii)(I) the physician has obtained approval for use of the drug in advance of its dispensing in

accordance with a prior authorization program described in subsection (d) of this section, or (II) the Secretary has reviewed and approved the State's determination under subparagraph (A); or (B) the Secretary determines that in the first calendar quarter of 1991, there were extenuating circumstances.

(4) Effect on existing agreements

In the case of a rebate agreement in effect between a State and a manufacturer on November 5, 1990, such agreement, for the initial agreement period specified therein, shall be considered to be a rebate agreement in compliance with this section with respect to that State, if the State agrees to report to the Secretary any rebates paid pursuant to the agreement and such agreement provides for a minimum aggregate rebate of 10 percent of the State's total expenditures under the State plan for coverage of the manufacturer's drugs under this subchapter. If, after the initial agreement period, the State establishes to the satisfaction of the Secretary that an agreement in effect on November 5, 1990, provides for rebates that are at least as large as the rebates otherwise required under this section, and the State agrees to report any rebates under the agreement to the Secretary, the agreement shall be considered to be a rebate agreement in compliance with the section for the renewal periods of such agreement.

(5) Limitation on prices of drugs purchased by covered entities

(A) Agreement with Secretary

A manufacturer meets the requirements of this paragraph if the manufacturer has entered into an agreement with the Secretary that meets the requirements of [section 256b](#) of this title with respect to covered outpatient drugs purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992.

(B) Covered entity defined

In this subsection, the term "covered entity" means an entity described in [section 256b\(a\)\(4\)](#) of this title and a children's hospital described in [section 1395ww\(d\)\(1\)\(B\)\(iii\)](#) of this title which meets the requirements of clauses (i) and (iii) of section 340B(b)(4)(L) of the Public Health Service Act [\[FN1\]](#) and which would meet the requirements of clause (ii) of such section if that clause were applied by taking into account the percentage of care provided by the hospital to patients eligible for medical assistance under a State plan under this subchapter.

(C) Establishment of alternative mechanism to ensure against duplicate discounts or rebates

If the Secretary does not establish a mechanism under [section 256b\(a\)\(5\)\(A\)](#) of this title within 12 months of November 4, 1992, the following requirements shall apply:

(i) Entities

Each covered entity shall inform the single State agency under [section 1396a\(a\)\(5\)](#) of this title when it is seeking reimbursement from the State plan for medical assistance described in [section 1396d\(a\)\(12\)](#) of this title with respect to a unit of any covered outpatient drug which is subject to an agreement under [section 256b\(a\)](#) of this title.

(ii) State agency

Each such single State agency shall provide a means by which a covered entity shall indicate on any drug reimbursement claims form (or format, where electronic claims management is used) that a unit of the drug that is the subject of the form is subject to an agreement under [section 256b](#) of this title, and not submit to any manufacturer a claim for a rebate payment under subsection (b) of this section with respect to such a drug.

(D) Effect of subsequent amendments

In determining whether an agreement under subparagraph (A) meets the requirements of [section 256b](#) of this title, the Secretary shall not take into account any amendments to such section that are enacted after November 4, 1992.

(E) Determination of compliance

A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of [section 256b](#) of this title (as in effect immediately after November 4, 1992) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after November 4, 1992.

(6) Requirements relating to master agreements for drugs procured by Department of Veterans Affairs and certain other Federal agencies

(A) In general

A manufacturer meets the requirements of this paragraph if the manufacturer complies with the provisions of [section 8126 of Title 38](#), including the requirement of entering into a master agreement with the Secretary of Veterans Affairs under such section.

(B) Effect of subsequent amendments

In determining whether a master agreement described in subparagraph (A) meets the requirements of [section 8126 of Title 38](#), the Secretary shall not take into account any amendments to such section that are enacted after November 4, 1992.

(C) Determination of compliance

A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of [section 8126 of Title 38](#), (as in effect immediately after November 4, 1992) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after November 4, 1992.

(7) Requirement for submission of utilization data for certain physician administered drugs

(A) Single source drugs

In order for payment to be available under [section 1396b\(a\)](#) of this title for a covered outpatient drug that is a single source drug that is physician administered under this subchapter (as determined by the Secretary), and that is administered on or after January 1, 2006, the State shall provide for the collection and submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section for drugs administered for which payment is made under this subchapter.

(B) Multiple source drugs

(i) Identification of most frequently physician administered multiple source drugs

Not later than January 1, 2007, the Secretary shall publish a list of the 20 physician administered multiple source drugs that the Secretary determines have the highest dollar volume of physician administered drugs dispensed under this subchapter. The Secretary may modify such list from year to year to reflect changes in such volume.

(ii) Requirement

In order for payment to be available under [section 1396b\(a\)](#) of this title for a covered outpatient drug that is a multiple source drug that is physician administered (as determined by the Secretary), that is on the list published under clause (i), and that is administered on or after January 1, 2008, the State shall provide for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section.

(C) Use of NDC codes

Not later than January 1, 2007, the information shall be submitted under subparagraphs (A) and (B)(ii) using National Drug Code codes unless the Secretary specifies that an alternative coding system should be used.

(D) Hardship waiver

The Secretary may delay the application of subparagraph (A) or (B)(ii), or both, in the case of a State to prevent hardship to States which require additional time to implement the reporting system required under the respective subparagraph.

(b) Terms of rebate agreement

(1) Periodic rebates

(A) In general

A rebate agreement under this subsection shall require the manufacturer to provide, to each State plan approved under this subchapter, a rebate for a rebate period in an amount specified in subsection (c) of this section for covered outpatient drugs of the manufacturer dispensed after December 31, 1990, for which payment was made under the State plan for such period. Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.

(B) Offset against medical assistance

Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) of this section or an agreement described in subsection (a)(4) of this section) in any quarter shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of [section 1396b\(a\)\(1\)](#) of this title.

(2) State provision of information

(A) State responsibility

Each State agency under this subchapter shall report to each manufacturer not later than 60 days after the end of each rebate period and in a form consistent with a standard reporting format established by the Secretary, information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed after

December 31, 1990, for which payment was made under the plan during the period, and shall promptly transmit a copy of such report to the Secretary.

(B) Audits

A manufacturer may audit the information provided (or required to be provided) under subparagraph (A). Adjustments to rebates shall be made to the extent that information indicates that utilization was greater or less than the amount previously specified.

(3) Manufacturer provision of price information

(A) In general

Each manufacturer with an agreement in effect under this section shall report to the Secretary--

(i) not later than 30 days after the last day of each rebate period under the agreement--

(I) on the average manufacturer price (as defined in subsection (k)(1) of this section) for covered outpatient drugs for the rebate period under the agreement (including for all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C.A. § 355(c)]); and

(II) for single source drugs and innovator multiple source drugs (including all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), on the manufacturer's best price (as defined in subsection (c)(1)(C) of this section) for such drugs for the rebate period under the agreement;

(ii) not later than 30 days after the date of entering into an agreement under this section on the average manufacturer price (as defined in subsection (k)(1) of this section) as of October 1, 1990 [FN2] for each of the manufacturer's covered outpatient drugs (including for such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act); and

(iii) for calendar quarters beginning on or after January 1, 2004, in conjunction with reporting required under clause (i) and by National Drug Code (including package size)--

(I) the manufacturer's average sales price (as defined in [section 1395w-3a\(c\)](#) of this title) and the total number of units specified under [section 1395w-3a\(b\)\(2\)\(A\)](#) of this title;

(II) if required to make payment under [section 1395w-3a](#) of this title, the manufacturer's wholesale acquisition cost, as defined in subsection (c)(6) of such section; and

(III) information on those sales that were made at a nominal price or otherwise described in [section 1395w-3a\(c\)\(2\)\(B\)](#) of this title;

for a drug or biological described in [subparagraph \(C\), \(D\), \(E\), or \(G\) of section 1395u\(o\)\(1\)](#) of this title or [section 1395rr\(b\)\(13\)\(A\)\(ii\)](#) of this title, and, for calendar quarters beginning on or after January 1, 2007 and only with respect to the information described in subclause (III), for covered outpatient drugs.

Information reported under this subparagraph is subject to audit by the Inspector General of the Department of Health and Human Services. Beginning July 1, 2006, the Secretary shall provide on a monthly basis to States under

subparagraph (D)(iv) the most recently reported average manufacturer prices for single source drugs and for multiple source drugs and shall, on at least a quarterly basis, update the information posted on the website under subparagraph (D)(v).

(B) Verification surveys of average manufacturer price and manufacturer's average sales price

The Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed \$100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of [section 1320a-7a](#) of this title (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(C) Penalties

(i) Failure to provide timely information

In the case of a manufacturer with an agreement under this section that fails to provide information required under subparagraph (A) on a timely basis, the amount of the penalty shall be increased by \$10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury, and, if such information is not reported within 90 days of the deadline imposed, the agreement shall be suspended for services furnished after the end of such 90-day period and until the date such information is reported (but in no case shall such suspension be for a period of less than 30 days).

(ii) False information

Any manufacturer with an agreement under this section that knowingly provides false information is subject to a civil money penalty in an amount not to exceed \$100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of [section 1320a-7a](#) of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(D) Confidentiality of information

Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph or under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A)(ii) of this section (other than the wholesale acquisition cost for purposes of carrying out [section 1395w-3a](#) of this title) is confidential and shall not be disclosed by the Secretary or the Secretary of Veterans Affairs or a State agency (or contractor therewith) in a form which discloses the identity of a specific manufacturer or wholesaler, prices charged for drugs by such manufacturer or wholesaler, except--

(i) as the Secretary determines to be necessary to carry out this section, to carry out [section 1395w-3a](#) of this title (including the determination and implementation of the payment amount), or to carry out [section 1395w-3b](#) of this title,

(ii) to permit the Comptroller General to review the information provided,

(iii) to permit the Director of the Congressional Budget Office to review the information provided,

(iv) to States to carry out this subchapter, and

(v) to the Secretary to disclose (through a website accessible to the public) average manufacturer prices.

The previous sentence shall also apply to information disclosed under [section 1395w-102\(d\)\(2\)](#) or [1395w-104\(c\)\(2\)\(E\)](#) of this title and drug pricing data reported under the first sentence of [section 1395w-141\(i\)\(1\)](#) of this title.

(4) Length of agreement

(A) In general

A rebate agreement shall be effective for an initial period of not less than 1 year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

(B) Termination

(i) By the Secretary

The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

(ii) By a manufacturer

A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

(iii) Effectiveness of termination

Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

(iv) Notice to States

In the case of a termination under this subparagraph, the Secretary shall provide notice of such termination to the States within not less than 30 days before the effective date of such termination.

(v) Application to terminations of other agreements

The provisions of this subparagraph shall apply to the terminations of agreements described in [section 256b\(a\)\(1\)](#) of this title and master agreements described in [section 8126\(a\) of Title 38](#).

(C) Delay before reentry

In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since the date of the termination, unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

(c) Determination of amount of rebate

(1) Basic rebate for single source drugs and innovator multiple source drugs

(A) In general

Except as provided in paragraph (2), the amount of the rebate specified in this subsection for a rebate period (as defined in subsection (k)(8) of this section) with respect to each dosage form and strength of a single source drug or an innovator multiple source drug shall be equal to the product of--

(i) the total number of units of each dosage form and strength paid for under the State plan in the rebate period (as reported by the State); and

(ii) subject to subparagraph (B)(ii), the greater of--

(I) the difference between the average manufacturer price and the best price (as defined in subparagraph (C)) for the dosage form and strength of the drug, or

(II) the minimum rebate percentage (specified in subparagraph (B)(i)) of such average manufacturer price,
for the rebate period.

(B) Range of rebates required

(i) Minimum rebate percentage

For purposes of subparagraph (A)(ii)(II), the "minimum rebate percentage" for rebate periods beginning--

(I) after December 31, 1990, and before October 1, 1992, is 12.5 percent;

(II) after September 30, 1992, and before January 1, 1994, is 15.7 percent;

(III) after December 31, 1993, and before January 1, 1995, is 15.4 percent;

(IV) after December 31, 1994, and before January 1, 1996, is 15.2 percent; and

(V) after December 31, 1995, is 15.1 percent.

(ii) Temporary limitation on maximum rebate amount

In no case shall the amount applied under subparagraph (A)(ii) for a rebate period beginning--

(I) before January 1, 1992, exceed 25 percent of the average manufacturer price; or

(II) after December 31, 1991, and before January 1, 1993, exceed 50 percent of the average manufacturer price.

(C) Best price defined

For purposes of this section--

(i) In general

The term “best price” means, with respect to a single source drug or innovator multiple source drug of a manufacturer (including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [[21 U.S.C.A. § 355\(c\)](#)]), the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding--

(I) any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home receiving funds under [section 1741 of Title 38](#), the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) of this section (including inpatient prices charged to hospitals described in [section 256b\(a\)\(4\)\(L\)](#) of this title);

(II) any prices charged under the Federal Supply Schedule of the General Services Administration;

(III) any prices used under a State pharmaceutical assistance program;

(IV) any depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government;

(V) the prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under [section 1395w-141](#) of this title; and

(VI) any prices charged which are negotiated by a prescription drug plan under part D of subchapter XVIII, by an MA-PD plan under part C of such subchapter with respect to covered part D drugs or by a qualified retiree prescription drug plan (as defined in [section 1395w-132\(a\)\(2\)](#) of this title) with respect to such drugs on behalf of individuals entitled to benefits under part A of subchapter XVIII or enrolled under part B of such subchapter.

(ii) Special rules

The term “best price”--

(I) shall be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section);

(II) shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package;

(III) shall not take into account prices that are merely nominal in amount; and

(IV) in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to

be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [[21 U.S.C.A. § 355\(c\)](#)], shall be inclusive of the lowest price for such authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding those prices described in subclauses (I) through (IV) of clause (i).

(iii) Application of auditing and recordkeeping requirements

With respect to a covered entity described in [section 256b\(a\)\(4\)\(L\)](#) of this title, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in [section 256b\(a\)\(5\)\(C\)](#) of this title.

(D) Limitation on sales at a nominal price

(i) In general

For purposes of subparagraph (C)(ii)(III) and subsection (b)(3)(A)(ii)(III) of this section, only sales by a manufacturer of covered outpatient drugs at nominal prices to the following shall be considered to be sales at a nominal price or merely nominal in amount:

(I) A covered entity described in [section 256b\(a\)\(4\)](#) of this title.

(II) An intermediate care facility for the mentally retarded.

(III) A State-owned or operated nursing facility.

(IV) An entity that--

(aa) is described in [section 501\(c\)\(3\) of the Internal Revenue Code of 1986](#) and exempt from tax under section 501(a) of such Act [[FN3](#)] or is State-owned or operated; and

(bb) would be a covered entity described in section 340(B)(a)(4) of the Public Health Service Act [[FN4](#)] insofar as the entity provides the same type of services to the same type of populations as a covered entity described in such section provides, but does not receive funding under a provision of law referred to in such section;

(V) A public or nonprofit entity, or an entity based at an institution of higher learning whose primary purpose is to provide health care services to students of that institution, that provides a service or services described under [section 300\(a\)](#) of this title.

(VI) Any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at a nominal price would be appropriate based on the factors described in clause (ii).

(ii) Factors

The factors described in this clause with respect to a facility or entity are the following:

(I) The type of facility or entity.

(II) The services provided by the facility or entity.

(III) The patient population served by the facility or entity.

(IV) The number of other facilities or entities eligible to purchase at nominal prices in the same service area.

(iii) Nonapplication

Clause (i) shall not apply with respect to sales by a manufacturer at a nominal price of covered outpatient drugs pursuant to a master agreement under section 8126 of Title 38.

(iv) Rule of construction

Nothing in this subparagraph shall be construed to alter any existing statutory or regulatory prohibition on services with respect to an entity described in clause (i)(IV), including the prohibition set forth in section 300a-6 of this title.

(2) Additional rebate for single source and innovator multiple source drugs

(A) In general

The amount of the rebate specified in this subsection for a rebate period, with respect to each dosage form and strength of a single source drug or an innovator multiple source drug, shall be increased by an amount equal to the product of--

(i) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State plan for the rebate period; and

(ii) the amount (if any) by which--

(I) the average manufacturer price for the dosage form and strength of the drug for the period, exceeds

(II) the average manufacturer price for such dosage form and strength for the calendar quarter beginning July 1, 1990 (without regard to whether or not the drug has been sold or transferred to an entity, including a division or subsidiary of the manufacturer, after the first day of such quarter), increased by the percentage by which the consumer price index for all urban consumers (United States city average) for the month before the month in which the rebate period begins exceeds such index for September 1990.

(B) Treatment of subsequently approved drugs

In the case of a covered outpatient drug approved by the Food and Drug Administration after October 1, 1990, clause (ii)(II) of subparagraph (A) shall be applied by substituting “the first full calendar quarter after the day on which the drug was first marketed” for “the calendar quarter beginning July 1, 1990” and “the month prior to the first month of the first full calendar quarter after the day on which the drug was first marketed” for “September 1990”.

(3) Rebate for other drugs

(A) In general

The amount of the rebate paid to a State for a rebate period with respect to each dosage form and strength of covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of--

(i) the applicable percentage (as described in subparagraph (B)) of the average manufacturer price for the dosage form and strength for the rebate period, and

(ii) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State plan for the rebate period.

(B) Applicable percentage defined

For purposes of subparagraph (A)(i), the “applicable percentage” for rebate periods beginning--

(i) before January 1, 1994, is 10 percent, and

(ii) after December 31, 1993, is 11 percent.

(d) Limitations on coverage of drugs

(1) Permissible restrictions

(A) A State may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).

(B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if--

(i) the prescribed use is not for a medically accepted indication (as defined in subsection (k)(6) of this section);

(ii) the drug is contained in the list referred to in paragraph (2);

(iii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) of this section or in effect pursuant to subsection (a)(4) of this section; or

(iv) the State has excluded coverage of the drug from its formulary established in accordance with paragraph (4).

(2) List of drugs subject to restriction

The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

(A) Agents when used for anorexia, weight loss, or weight gain.

(B) Agents when used to promote fertility.

(C) Agents when used for cosmetic purposes or hair growth.

(D) Agents when used for the symptomatic relief of cough and colds.

(E) Agents when used to promote smoking cessation.

(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(G) Nonprescription drugs.

(H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(I) Barbiturates.

(J) Benzodiazepines.

(K) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

(3) Update of drug listings

The Secretary shall, by regulation, periodically update the list of drugs or classes of drugs described in paragraph (2) or their medical uses, which the Secretary has determined, based on data collected by surveillance and utilization review programs of State medical assistance programs, to be subject to clinical abuse or inappropriate use.

(4) Requirements for formularies

A State may establish a formulary if the formulary meets the following requirements:

(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State (or, at the option of the State, the State's drug use review board established under subsection (g)(3) of this section).

(B) Except as provided in subparagraph (C), the formulary includes the covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under subsection (a) of this section (other than any drug excluded from coverage or otherwise restricted under paragraph (2)).

(C) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling (or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act [21 U.S.C.A. § 301 et seq.] but is a medically accepted indication, based on information from the appropriate compendia described in subsection (k)(6) of this section), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

(D) The State plan permits coverage of a drug excluded from the formulary (other than any drug excluded from coverage or otherwise restricted under paragraph (2)) pursuant to a prior authorization program that is consistent with paragraph (5).

(E) The formulary meets such other requirements as the Secretary may impose in order to achieve program savings consistent with protecting the health of program beneficiaries.

A prior authorization program established by a State under paragraph (5) is not a formulary subject to the requirements of this paragraph.

(5) Requirements of prior authorization programs

A State plan under this subchapter may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6) of this section) only if the system providing for such approval--

(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

(6) Other permissible restrictions

A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals in any manner authorized under this chapter.

(e) Treatment of pharmacy reimbursement limits**(1) In general**

During the period beginning on January 1, 1991, and ending on December 31, 1994--

(A) a State may not reduce the payment limits established by regulation under this subchapter or any limitation described in paragraph (3) with respect to the ingredient cost of a covered outpatient drug or the dispensing fee for such a drug below the limits in effect as of January 1, 1991, and

(B) except as provided in paragraph (2), the Secretary may not modify by regulation the formula established under [sections 447.331 through 447.334 of title 42, Code of Federal Regulations](#), in effect on November 5, 1990, to reduce the limits described in subparagraph (A).

(2) Special rule

If a State is not in compliance with the regulations described in paragraph (1)(B), paragraph (1)(A) shall not apply to such State until such State is in compliance with such regulations.

(3) Effect on State maximum allowable cost limitations

This section shall not supersede or affect provisions in effect prior to January 1, 1991, or after December 31, 1994, relating to any maximum allowable cost limitation established by a State for payment by the State for covered outpatient drugs, and rebates shall be made under this section without regard to whether or not payment by the State for such drugs is subject to such a limitation or the amount of such a limitation.

(4) Establishment of upper payment limits

Subject to paragraph (5), the Secretary shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more (or, effective January 1, 2007, two or more) products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

(5) Use of AMP in upper payment limits

Effective January 1, 2007, in applying the Federal upper reimbursement limit under [paragraph \(4\) and section 447.332\(b\) of title 42 of the Code of Federal Regulations](#), the Secretary shall substitute 250 percent of the average manufacturer price (as computed without regard to customary prompt pay discounts extended to wholesalers) for 150 percent of the published price.

(f) Survey of retail prices; State payment and utilization rates; and performance rankings

(1) Survey of retail prices

(A) Use of vendor

The Secretary may contract services for--

(i) the determination on a monthly basis of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available); and

(ii) the notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available.

(B) Secretary response to notification of availability of multiple source products

If contractor notifies the Secretary under subparagraph (A)(ii) that a drug product described in such subparagraph has become generally available, the Secretary shall make a determination, within 7 days after receiving such notification, as to whether the product is now described in subsection (e)(4) of this section.

(C) Use of competitive bidding

In contracting for such services, the Secretary shall competitively bid for an outside vendor that has a demonstrated history in--

(i) surveying and determining, on a representative nationwide basis, retail prices for ingredient costs of prescription drugs;

(ii) working with retail pharmacies, commercial payers, and States in obtaining and disseminating such price information; and

(iii) collecting and reporting such price information on at least a monthly basis.

In contracting for such services, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this subsection, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(D) Additional provisions

A contract with a vendor under this paragraph shall include such terms and conditions as the Secretary shall specify, including the following:

(i) The vendor must monitor the marketplace and report to the Secretary each time there is a new covered outpatient drug generally available.

(ii) The vendor must update the Secretary no less often than monthly on the retail survey prices for covered outpatient drugs.

(iii) The contract shall be effective for a term of 2 years.

(E) Availability of information to States

Information on retail survey prices obtained under this paragraph, including applicable information on single source drugs, shall be provided to States on at least a monthly basis. The Secretary shall devise and implement a means for providing access to each State agency designated under [section 1396a\(a\)\(5\)](#) of this title with responsibility for the administration or supervision of the administration of the State plan under this subchapter of the retail survey price determined under this paragraph.

(2) Annual State report

Each State shall annually report to the Secretary information on--

(A) the payment rates under the State plan under this subchapter for covered outpatient drugs;

(B) the dispensing fees paid under such plan for such drugs; and

(C) utilization rates for noninnovator multiple source drugs under such plan.

(3) Annual State performance rankings

(A) Comparative analysis

The Secretary annually shall compare, for the 50 most widely prescribed drugs identified by the Secretary, the national retail sales price data (collected under paragraph (1)) for such drugs with data on prices under this subchapter for each such drug for each State.

(B) Availability of information

The Secretary shall submit to Congress and the States full information regarding the annual rankings made under subparagraph (A).

(4) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human

Services \$5,000,000 for each of fiscal years 2006 through 2010 to carry out this subsection.

(g) Drug use review

(1) In general

(A) In order to meet the requirement of [section 1396b\(i\)\(10\)\(B\)](#) of this title, a State shall provide, by not later than January 1, 1993, for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

(i) compendia which shall consist of the following:

(I) American Hospital Formulary Service Drug Information;

(II) United States Pharmacopeia-Drug Information (or its successor publications); and

(III) the DRUGDEX Information System; and

(IV) Repealed. [Pub.L. 108-173, Title I, § 101\(e\)\(9\)\(B\)](#), Dec. 8, 2003, 117 Stat. 2152.

(ii) the peer-reviewed medical literature.

(C) The Secretary, under the procedures established in [section 1396b](#) of this title, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing [section 1396r](#) of this title, currently at [section 483.60 of title 42, Code of Federal Regulations](#).

(2) Description of program

Each drug use review program shall meet the following requirements for covered outpatient drugs:

(A) Prospective drug review

(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this subchapter, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-

drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this subchapter by pharmacists which includes at least the following:

(I) The pharmacist must offer to discuss with each individual receiving benefits under this subchapter or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following:

(aa) The name and description of the medication.

(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

(cc) Special directions and precautions for preparation, administration and use by the patient.

(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

(ee) Techniques for self-monitoring drug therapy.

(ff) Proper storage.

(gg) Prescription refill information.

(hh) Action to be taken in the event of a missed dose.

(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this subchapter:

(aa) Name, address, telephone number, date of birth (or age) and gender.

(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

(cc) Pharmacist comments relevant to the individual's drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this subchapter or caregiver of such individual refuses such consultation, or to require verification of the offer to provide consultation or a refusal of such offer.

(B) Retrospective drug use review

The program shall provide, through its mechanized drug claims processing and information retrieval systems (approved

by the Secretary under [section 1396b\(r\)](#) of this title) or otherwise, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits under this subchapter, or associated with specific drugs or groups of drugs.

(C) Application of standards

The program shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using the compendia and literature referred to in subsection [\[FN5\]](#) (1)(B) as the source of standards for such assessment) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

(D) Educational program

The program shall, through its State drug use review board established under paragraph (3), either directly or through contracts with accredited health care educational institutions, State medical societies or State pharmacists associations/societies or other organizations as specified by the State, and using data provided by the State drug use review board on common drug therapy problems, provide for active and ongoing educational outreach programs (including the activities described in paragraph (3)(C)(iii) of this subsection) to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices.

(3) State drug use review board

(A) Establishment

Each State shall provide for the establishment of a drug use review board (hereinafter referred to as the “DUR Board”) either directly or through a contract with a private organization.

(B) Membership

The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

- (i)** The clinically appropriate prescribing of covered outpatient drugs.
- (ii)** The clinically appropriate dispensing and monitoring of covered outpatient drugs.
- (iii)** Drug use review, evaluation, and intervention.
- (iv)** Medical quality assurance.

The membership of the DUR Board shall be made up at least 1/3 but no more than 51 percent licensed and actively practicing physicians and at least 1/3 * * * [\[FN6\]](#) licensed and actively practicing pharmacists.

(C) Activities

The activities of the DUR Board shall include but not be limited to the following:

(i) Retrospective DUR as defined in section [\[FNS\]](#) (2)(B).

(ii) Application of standards as defined in section (2)(C).

(iii) Ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews performed under this subsection. Intervention programs shall include, in appropriate instances, at least:

(I) information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;

(II) written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;

(III) use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and

(IV) intensified review or monitoring of selected prescribers or dispensers.

The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

(D) Annual report

Each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State's drug use review program.

(h) Electronic claims management

(1) In general

In accordance with chapter 35 of Title 44 (relating to coordination of Federal information policy), the Secretary shall encourage each State agency to establish, as its principal means of processing claims for covered outpatient drugs under this subchapter, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

(2) Encouragement

In order to carry out paragraph (1)--

(A) for calendar quarters during fiscal years 1991 and 1992, expenditures under the State plan attributable to development of a system described in paragraph (1) shall receive Federal financial participation under [section 1396b\(a\)\(3\)\(A\)\(i\)](#) of this title (at a matching rate of 90 percent) if the State acquires, through applicable competitive procurement process in the State, the most cost-effective telecommunications network and automatic data processing services and equipment; and

(B) the Secretary may permit, in the procurement described in subparagraph (A) in the application of part 433 of title 42, Code of Federal Regulations, and parts 95, 205, and 307 of title 45, Code of Federal Regulations, the substitution of the State's request for proposal in competitive procurement for advance [\[FN7\]](#) planning and implementation documents otherwise required.

(i) Omitted

(j) Exemption of organized health care settings

(1) Covered outpatient drugs dispensed by health maintenance organizations, including medicaid managed care organizations that contract under [section 1396b\(m\)](#) of this title, are not subject to the requirements of this section.

(2) The State plan shall provide that a hospital (providing medical assistance under such plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the plan no more than the hospital's purchasing costs for covered outpatient drugs (as determined under the State plan) shall not be subject to the requirements of this section.

(3) Nothing in this subsection shall be construed as providing that amounts for covered outpatient drugs paid by the institutions described in this subsection should not be taken into account for purposes of determining the best price as described in subsection (c) of this section.

(k) Definitions

In this section--

(1) Average manufacturer price

(A) In general

Subject to subparagraph (B), the term “average manufacturer price” means, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade.

(B) Exclusion of customary prompt pay discounts extended to wholesalers

The average manufacturer price for a covered outpatient drug shall be determined without regard to customary prompt pay discounts extended to wholesalers.

(C) Inclusion of section 505(c) drugs

In the case of a manufacturer that approves, allows, or otherwise permits any drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [[21 U.S.C.A. § 355\(c\)](#)], such term shall be inclusive of the average price paid for such drug by wholesalers for drugs distributed to the retail pharmacy class of trade.

(2) Covered outpatient drug

Subject to the exceptions in paragraph (3), the term “covered outpatient drug” means--

(A) of those drugs which are treated as prescribed drugs for purposes of [section 1396d\(a\)\(12\)](#) of this title, a drug which may be dispensed only upon prescription (except as provided in paragraph (5)), and--

(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act [[21 U.S.C.A. § 355](#) or [357](#)] or which is approved under section 505(j) of such Act [[21 U.S.C.A. § 355\(j\)](#)];

(ii) (I) which was commercially used or sold in the United States before October 10, 1962, or which is identical, similar, or related (within the meaning of [section 310.6\(b\)\(1\) of title 21 of the Code of Federal Regulations](#)) to such a drug; and (II) which has not been the subject of a final determination by the Secretary that it is a “new drug” (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act [[21 U.S.C.A. § 321\(p\)](#)]) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act [[21 U.S.C.A. § 331](#), [332\(a\)](#), or [334\(a\)](#)] to enforce section 502(f) or 505(a) of such Act [[21 U.S.C.A. § 352\(f\)](#) or [355\(a\)](#)]; or

(iii) (I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of [section 310.6\(b\)\(1\) of title 21 of the Code of Federal Regulations](#)) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act [[21 U.S.C.A. § 355\(e\)](#)] on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

(B) a biological product, other than a vaccine which--

(i) may only be dispensed upon prescription,

(ii) is licensed under [section 262](#) of this title, and

(iii) is produced at an establishment licensed under such section to produce such product; and

(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act [[21 U.S.C.A. § 356](#)].

(3) Limiting definition

The term “covered outpatient drug” does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this subchapter as part of payment for the following and not as direct reimbursement for the drug):

(A) Inpatient hospital services.

(B) Hospice services.

(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

(D) Physicians' services.

(E) Outpatient hospital services.

(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.

(G) Other laboratory and x-ray services.

(H) Renal dialysis.

Such term also does not include any such drug or product for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological [FN8] used for a medical indication which is not a medically accepted indication. Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C) of this section) for such drug, biological product, or insulin.

(4) Nonprescription drugs

If a State plan for medical assistance under this subchapter includes coverage of prescribed drugs as described in section 1396d(a)(12) of this title and permits coverage of drugs which may be sold without a prescription (commonly referred to as "over-the-counter" drugs), if they are prescribed by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

(5) Manufacturer

The term "manufacturer" means any entity which is engaged in--

(A) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or

(B) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products.

Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) Medically accepted indication

The term "medically accepted indication" means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act [21 U.S.C.A. § 301 et seq.], or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (g)(1)(B)(i) of this section.

(7) Multiple source drug; innovator multiple source drug; noninnovator multiple source drug; single source drug

(A) Defined

(i) Multiple source drug

The term “multiple source drug” means, with respect to a rebate period, a covered outpatient drug (not including any drug described in paragraph (5)) for which there [FN9] at least 1 other drug product which--

(I) is rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of “Approved Drug Products with Therapeutic Equivalence Evaluations”),

(II) except as provided in subparagraph (B), is pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and

(III) is sold or marketed in the State during the period.

(ii) Innovator multiple source drug

The term “innovator multiple source drug” means a multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(iii) Noninnovator multiple source drug

The term “noninnovator multiple source drug” means a multiple source drug that is not an innovator multiple source drug.

(iv) Single source drug

The term “single source drug” means a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

(B) Exception

Subparagraph (A)(1)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(1)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

(C) Definitions

For purposes of this paragraph--

(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity;

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence; and

(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.

(8) Rebate period

The term “rebate period” means, with respect to an agreement under subsection (a) of this section, a calendar quarter or other period specified by the Secretary with respect to the payment of rebates under such agreement.

(9) State agency

The term “State agency” means the agency designated under [section 1396a\(a\)\(5\)](#) of this title to administer or supervise the administration of the State plan for medical assistance.

[\[FN1\]](#) So in original. Probably should read “clauses (i) and (iii) of section 340B(a)(4)(L) of the Public Health Service Act”, which is classified to [42 U.S.C.A. § 256b\(a\)\(4\)\(L\)\(i\)](#) and (iii). See References in Text notes set out under this section.

[\[FN2\]](#) So in original. A comma probably should appear here.

[\[FN3\]](#) So in original. Probably should read “such Code”.

[\[FN4\]](#) So in original. Probably should read “340B(a)(4) of the Public Health Service Act”, which is classified to [42 U.S.C.A. § 256b](#).

[\[FN5\]](#) So in original. Probably should be “paragraph”.

[\[FN6\]](#) So in original.

[\[FN7\]](#) So in original. Probably should be “advanced”.

[\[FN8\]](#) So in original. Probably should be “biological product”.

[\[FN9\]](#) So in original.

[§ 1396s. Program for distribution of pediatric vaccines](#)

(a) Establishment of program

(1) In general

In order to meet the requirement of [section 1396a\(a\)\(62\)](#) of this title, each State shall establish a pediatric vaccine distribution program (which may be administered by the State department of health), consistent with the requirements of this section, under which--

(A) each vaccine-eligible child (as defined in subsection (b) of this section), in receiving an immunization with a qualified pediatric vaccine (as defined in subsection (h)(8) of this section) from a program-registered provider (as defined in subsection (c) of this section) on or after October 1, 1994, is entitled to receive the immunization without charge for the cost of such vaccine; and

(B) (i) each program-registered provider who administers such a pediatric vaccine to a vaccine-eligible child on or after such date is entitled to receive such vaccine under the program without charge either for the vaccine or its delivery to the

provider, and (ii) no vaccine is distributed under the program to a provider unless the provider is a program-registered provider.

(2) Delivery of sufficient quantities of pediatric vaccines to immunize federally vaccine-eligible children

(A) In general

The Secretary shall provide under subsection (d) of this section for the purchase and delivery on behalf of each State meeting the requirement of [section 1396a\(a\)\(62\)](#) of this title (or, with respect to vaccines administered by an Indian tribe or tribal organization to Indian children, directly to the tribe or organization), without charge to the State, of such quantities of qualified pediatric vaccines as may be necessary for the administration of such vaccines to all federally vaccine-eligible children in the State on or after October 1, 1994. This paragraph constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the purchase and delivery to States of the vaccines (or payment under subparagraph (C)) in accordance with this paragraph.

(B) Special rules where vaccine is unavailable

To the extent that a sufficient quantity of a vaccine is not available for purchase or delivery under subsection (d) of this section, the Secretary shall provide for the purchase and delivery of the available vaccine in accordance with priorities established by the Secretary, with priority given to federally vaccine-eligible children unless the Secretary finds there are other public health considerations.

(C) Special rules where State is a manufacturer

(i) Payments in lieu of vaccines

In the case of a State that manufactures a pediatric vaccine the Secretary, instead of providing the vaccine on behalf of a State under subparagraph (A), shall provide to the State an amount equal to the value of the quantity of such vaccine that otherwise would have been delivered on behalf of the State under such subparagraph, but only if the State agrees that such payments will only be used for purposes relating to pediatric immunizations.

(ii) Determination of value

In determining the amount to pay a State under clause (i) with respect to a pediatric vaccine, the value of the quantity of vaccine shall be determined on the basis of the price in effect for the qualified pediatric vaccine under contracts under subsection (d) of this section. If more than 1 such contract is in effect, the Secretary shall determine such value on the basis of the average of the prices under the contracts, after weighting each such price in relation to the quantity of vaccine under the contract involved.

(b) Vaccine-eligible children

For purposes of this section:

(1) In general

The term “vaccine-eligible child” means a child who is a federally vaccine-eligible child (as defined in paragraph (2)) or a State vaccine-eligible child (as defined in paragraph (3)).

(2) Federally vaccine-eligible child

(A) In general

The term “federally vaccine-eligible child” means any of the following children:

- (i) A medicaid-eligible child.
- (ii) A child who is not insured.
- (iii) A child who (I) is administered a qualified pediatric vaccine by a federally-qualified health center (as defined in [section 1396d\(1\)\(2\)\(B\)](#) of this title) or a rural health clinic (as defined in [section 1396d\(1\)\(1\)](#) of this title), and (II) is not insured with respect to the vaccine.
- (iv) A child who is an Indian (as defined in subsection (h)(3) of this section).

(B) Definitions

In subparagraph (A):

(i) The term “medicaid-eligible” means, with respect to a child, a child who is entitled to medical assistance under a state [\[FN1\]](#) plan approved under this subchapter.

(ii) The term “insured” means, with respect to a child--

(I) for purposes of subparagraph (A)(ii), that the child is enrolled under, and entitled to benefits under, a health insurance policy or plan, including a group health plan, a prepaid health plan, or an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 [[29 U.S.C.A. § 1001 et seq.](#)]; and

(II) for purposes of subparagraph (A)(iii)(II) with respect to a pediatric vaccine, that the child is entitled to benefits under such a health insurance policy or plan, but such benefits are not available with respect to the cost of the pediatric vaccine.

(3) State vaccine-eligible child

The term “State vaccine-eligible child” means, with respect to a State and a qualified pediatric vaccine, a child who is within a class of children for which the State is purchasing the vaccine pursuant to subsection (d)(4)(B) of this section.

(c) Program-registered providers

(1) Defined

In this section, except as otherwise provided, the term “program-registered provider” means, with respect to a State, any health care provider that--

(A) is licensed or otherwise authorized for administration of pediatric vaccines under the law of the State in which the administration occurs (subject to [section 254f\(e\)](#) of this title), without regard to whether or not the provider participates in the plan under this subchapter;

(B) submits to the State an executed provider agreement described in paragraph (2); and

(C) has not been found, by the Secretary or the State, to have violated such agreement or other applicable requirements established by the Secretary or the State consistent with this section.

(2) Provider agreement

A provider agreement for a provider under this paragraph is an agreement (in such form and manner as the Secretary may require) that the provider agrees as follows:

(A)(i) Before administering a qualified pediatric vaccine to a child, the provider will ask a parent of the child such questions as are necessary to determine whether the child is a vaccine-eligible child, but the provider need not independently verify the answers to such questions.

(ii) The provider will, for a period of time specified by the Secretary, maintain records of responses made to the questions.

(iii) The provider will, upon request, make such records available to the State and to the Secretary, subject to [section 1396a\(a\)\(7\)](#) of this title.

(B)(i) Subject to clause (ii), the provider will comply with the schedule, regarding the appropriate periodicity, dosage, and contraindications applicable to pediatric vaccines, that is established and periodically reviewed and, as appropriate, revised by the advisory committee referred to in subsection (e) of this section, except in such cases as, in the provider's medical judgment subject to accepted medical practice, such compliance is medically inappropriate.

(ii) The provider will provide pediatric vaccines in compliance with applicable State law, including any such law relating to any religious or other exemption.

(C)(i) In administering a qualified pediatric vaccine to a vaccine-eligible child, the provider will not impose a charge for the cost of the vaccine. A program-registered provider is not required under this section to administer such a vaccine to each child for whom an immunization with the vaccine is sought from the provider.

(ii) The provider may impose a fee for the administration of a qualified pediatric vaccine so long as the fee in the case of a federally vaccine-eligible child does not exceed the costs of such administration (as determined by the Secretary based on actual regional costs for such administration).

(iii) The provider will not deny administration of a qualified pediatric vaccine to a vaccine-eligible child due to the inability of the child's parent to pay an administration fee.

(3) Encouraging involvement of providers

Each program under this section shall provide, in accordance with criteria established by the Secretary--

(A) for encouraging the following to become program-registered providers: private health care providers, the Indian Health Service, health care providers that receive funds under title V of the Indian Health Care Improvement Act [[25 U.S.C.A. § 1651 et seq.](#)], and health programs or facilities operated by Indian tribes or tribal organizations; and

(B) for identifying, with respect to any population of vaccine-eligible children a substantial portion of whose parents have a limited ability to speak the English language, those program-registered providers who are able to communicate

with the population involved in the language and cultural context that is most appropriate.

(4) State requirements

Except as the Secretary may permit in order to prevent fraud and abuse and for related purposes, a State may not impose additional qualifications or conditions, in addition to the requirements of paragraph (1), in order that a provider qualify as a program-registered provider under this section. This subsection does not limit the exercise of State authority under [section 1396n\(b\)](#) of this title.

(d) Negotiation of contracts with manufacturers

(1) In general

For the purpose of meeting obligations under this section, the Secretary shall negotiate and enter into contracts with manufacturers of pediatric vaccines consistent with the requirements of this subsection and, to the maximum extent practicable, consolidate such contracting with any other contracting activities conducted by the Secretary to purchase vaccines. The Secretary may enter into such contracts under which the Federal Government is obligated to make outlays, the budget authority for which is not provided for in advance in appropriations Acts, for the purchase and delivery of pediatric vaccines under subsection (a)(2)(A) of this section.

(2) Authority to decline contracts

The Secretary may decline to enter into such contracts and may modify or extend such contracts.

(3) Contract price

(A) In general

The Secretary, in negotiating the prices at which pediatric vaccines will be purchased and delivered from a manufacturer under this subsection, shall take into account quantities of vaccines to be purchased by States under the option under paragraph (4)(B).

(B) Negotiation of discounted price for current vaccines

With respect to contracts entered into under this subsection for a pediatric vaccine for which the Centers for Disease Control and Prevention has a contract in effect under [section 247b\(j\)\(1\)](#) of this title as of May 1, 1993, no price for the purchase of such vaccine for vaccine-eligible children shall be agreed to by the Secretary under this subsection if the price per dose of such vaccine (including delivery costs and any applicable excise tax established under [section 4131 of the Internal Revenue Code of 1986](#)) exceeds the price per dose for the vaccine in effect under such a contract as of such date increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) from May 1993 to the month before the month in which such contract is entered into.

(C) Negotiation of discounted price for new vaccines

With respect to contracts entered into for a pediatric vaccine not described in subparagraph (B), the price for the purchase of such vaccine shall be a discounted price negotiated by the Secretary that may be established without regard to such subparagraph.

(4) Quantities and terms of delivery

Under such contracts--

(A) the Secretary shall provide, consistent with paragraph (6), for the purchase and delivery on behalf of States (and tribes and tribal organizations) of quantities of pediatric vaccines for federally vaccine-eligible children; and

(B) each State, at the option of the State, shall be permitted to obtain additional quantities of pediatric vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through purchasing the vaccines from the manufacturers at the applicable price negotiated by the Secretary consistent with paragraph (3), if (i) the State agrees that the vaccines will be used to provide immunizations only for children who are not federally vaccine-eligible children and (ii) the State provides to the Secretary such information (at a time and manner specified by the Secretary, including in advance of negotiations under paragraph (1)) as the Secretary determines to be necessary, to provide for quantities of pediatric vaccines for the State to purchase pursuant to this subsection and to determine annually the percentage of the vaccine market that is purchased pursuant to this section and this subparagraph.

The Secretary shall enter into the initial negotiations under the preceding sentence not later than 180 days after August 10, 1993.

(5) Charges for shipping and handling

The Secretary may enter into a contract referred to in paragraph (1) only if the manufacturer involved agrees to submit to the Secretary such reports as the Secretary determines to be appropriate to assure compliance with the contract and if, with respect to a State program under this section that does not provide for the direct delivery of qualified pediatric vaccines, the manufacturer involved agrees that the manufacturer will provide for the delivery of the vaccines on behalf of the State in accordance with such program and will not impose any charges for the costs of such delivery (except to the extent such costs are provided for in the price established under paragraph (3)).

(6) Assuring adequate supply of vaccines

The Secretary, in negotiations under paragraph (1), shall negotiate for quantities of pediatric vaccines such that an adequate supply of such vaccines will be maintained to meet unanticipated needs for the vaccines. For purposes of the preceding sentence, the Secretary shall negotiate for a 6-month supply of vaccines in addition to the quantity that the Secretary otherwise would provide for in such negotiations. In carrying out this paragraph, the Secretary shall consider the potential for outbreaks of the diseases with respect to which the vaccines have been developed.

(7) Multiple suppliers

In the case of the pediatric vaccine involved, the Secretary shall, as appropriate, enter into a contract referred to in paragraph (1) with each manufacturer of the vaccine that meets the terms and conditions of the Secretary for an award of such a contract (including terms and conditions regarding safety and quality). With respect to multiple contracts entered into pursuant to this paragraph, the Secretary may have in effect different prices under each of such contracts and, with respect to a purchase by States pursuant to paragraph (4)(B), the Secretary shall determine which of such contracts will be applicable to the purchase.

(e) Use of pediatric vaccines list

The Secretary shall use, for the purpose of the purchase, delivery, and administration of pediatric vaccines under this section, the list established (and periodically reviewed and as appropriate revised) by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease

Control and Prevention).

(f) Requirement of state maintenance of immunization laws

In the case of a State that had in effect as of May 1, 1993, a law that requires some or all health insurance policies or plans to provide some coverage with respect to a pediatric vaccine, a State program under this section does not comply with the requirements of this section unless the State certifies to the Secretary that the State has not modified or repealed such law in a manner that reduces the amount of coverage so required.

(g) Termination

This section, and the requirement of [section 1396a\(a\)\(62\)](#) of this title, shall cease to be in effect beginning on such date as may be prescribed in Federal law providing for immunization services for all children as part of a broad-based reform of the national health care system.

(h) Definitions

For purposes of this section:

- (1) The term “child” means an individual 18 years of age or younger.
- (2) The term “immunization” means an immunization against a vaccine-preventable disease.
- (3) The terms “Indian”, “Indian tribe” and “tribal organization” have the meanings given such terms in section 4 of the Indian Health Care Improvement Act [\[25 U.S.C.A. § 1603\]](#).
- (4) The term “manufacturer” means any corporation, organization, or institution, whether public or private (including Federal, State, and local departments, agencies, and instrumentalities), which manufactures, imports, processes, or distributes under its label any pediatric vaccine. The term “manufacture” means to manufacture, import, process, or distribute a vaccine.
- (5) The term “parent” includes, with respect to a child, an individual who qualifies as a legal guardian under State law.
- (6) The term “pediatric vaccine” means a vaccine included on the list under subsection (e) of this section.
- (7) The term “program-registered provider” has the meaning given such term in subsection (c) of this section.
- (8) The term “qualified pediatric vaccine” means a pediatric vaccine with respect to which a contract is in effect under subsection (d) of this section.
- (9) The terms “vaccine-eligible child”, “federally vaccine-eligible child”, and “State vaccine-eligible child” have the meaning given such terms in subsection (b) of this section.

[\[FN1\]](#) So in original. Probably should be capitalized.

[§ 1396t. Home and community care for functionally disabled elderly individuals](#)

(a) “Home and community care” defined

In this subchapter, the term “home and community care” means one or more of the following services furnished to an individual who has been determined, after an assessment under subsection (c) of this section, to be a functionally disabled elderly individual, furnished in accordance with an individual community care plan (established and periodically reviewed and revised by a qualified community care case manager under subsection (d) of this section):

- (1) Homemaker/home health aide services.
 - (2) Chore services.
 - (3) Personal care services.
 - (4) Nursing care services provided by, or under the supervision of, a registered nurse.
 - (5) Respite care.
 - (6) Training for family members in managing the individual.
 - (7) Adult day care.
 - (8) In the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).
 - (9) Such other home and community-based services (other than room and board) as the Secretary may approve.
- (b) “Functionally disabled elderly individual” defined

- (1) In general

In this subchapter, the term “functionally disabled elderly individual” means an individual who--

- (A) is 65 years of age or older,
 - (B) is determined to be a functionally disabled individual under subsection (c) of this section, and
 - (C) subject to [section 1396a\(f\)](#) of this title (as applied consistent with [section 1396a\(r\)\(2\)](#) of this title), is receiving supplemental security income benefits under subchapter XVI of this chapter (or under a State plan approved under subchapter XVI of this chapter or, at the option of the State, is described in [section 1396a\(a\)\(10\)\(C\)](#) of this title.
- (2) Treatment of certain individuals previously covered under a waiver
 - (A) In the case of a State which--
 - (i) at the time of its election to provide coverage for home and community care under this section has a waiver approved under [section 1396n\(c\)](#) of this title or 1396n(d) of this title with respect to individuals 65 years of age or older, and
 - (ii) subsequently discontinues such waiver, individuals who were eligible for benefits under the waiver as of the date of its discontinuance and who would, but for income or resources, be eligible for medical assistance for home and commu-

nity care under the plan shall, notwithstanding any other provision of this subchapter, be deemed a functionally disabled elderly individual for so long as the individual would have remained eligible for medical assistance under such waiver.

(B) In the case of a State which used a health insuring organization before January 1, 1986, and which, as of December 31, 1990, had in effect a waiver under [section 1315](#) of this title that provides under the State plan under this subchapter for personal care services for functionally disabled individuals, the term “functionally disabled elderly individual” may include, at the option of the State, an individual who--

(i) is 65 years of age or older or is disabled (as determined under the supplemental security income program under subchapter XVI of this chapter);

(ii) is determined to meet the test of functional disability applied under the waiver as of such date; and

(iii) meets the resource requirement and income standard that apply in the State to individuals described in [section 1396a\(a\)\(10\)\(A\)\(ii\)\(V\)](#) of this title.

(3) Use of projected income

In applying [section 1396b\(f\)\(1\)](#) of this title in determining the eligibility of an individual (described in [section 1396a\(a\)\(10\)\(C\)](#) of this title) for medical assistance for home and community care, a State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income) over a period of up to 6 months.

(c) Determinations of functional disability

(1) In general

In this section, an individual is “functionally disabled” if the individual--

(A) is unable to perform without substantial assistance from another individual at least 2 of the following 3 activities of daily living: toileting, transferring, and eating; or

(B) has a primary or secondary diagnosis of Alzheimer's disease and is (i) unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring, and eating; or (ii) cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or herself or others.

(2) Assessments of functional disability

(A) Requests for assessments

If a State has elected to provide home and community care under this section, upon the request of an individual who is 65 years of age or older and who meets the requirements of subsection (b)(1)(C) of this section (or another person on such individual's behalf), the State shall provide for a comprehensive functional assessment under this subparagraph which--

(i) is used to determine whether or not the individual is functionally disabled,

(ii) is based on a uniform minimum data set specified by the Secretary under subparagraph (C)(i), and

(iii) uses an instrument which has been specified by the State under subparagraph (B).

No fee may be charged for such an assessment.

(B) Specification of assessment instrument

The State shall specify the instrument to be used in the State in complying with the requirement of subparagraph (A)(iii) which instrument shall be--

(i) one of the instruments designated under subparagraph (C)(ii); or

(ii) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary in subparagraph (C)(i).

(C) Specification of assessment data set and instruments

The Secretary shall--

(i) not later than July 1, 1991--

(I) specify a minimum data set of core elements and common definitions for use in conducting the assessments required under subparagraph (A); and

(II) establish guidelines for use of the data set; and

(ii) by not later than July 1, 1991, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subparagraph (B) for use in complying with the requirements of subparagraph (A).

(D) Periodic review

Each individual who qualifies as a functionally disabled elderly individual shall have the individual's assessment periodically reviewed and revised not less often than once every 12 months.

(E) Conduct of assessment by interdisciplinary teams

An assessment under subparagraph (A) and a review under subparagraph (D) must be conducted by an interdisciplinary team designated by the State. The Secretary shall permit a State to provide for assessments and reviews through teams under contracts--

(i) with public organizations; or

(ii) with nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, community care or nursing facility services.

(F) Contents of assessment

The interdisciplinary team must--

(i) identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

(ii) based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

The results of such an assessment or review shall be used in establishing, reviewing, and revising the individual's ICCP under subsection (d)(1) of this section.

(G) Appeal procedures

Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (F).

(d) Individual community care plan (ICCP)

(1) Individual community care plan defined

In this section, the terms "individual community care plan" and "ICCP" mean, with respect to a functionally disabled elderly individual, a written plan which--

(A) is established, and is periodically reviewed and revised, by a qualified case manager after a face-to-face interview with the individual or primary caregiver and based upon the most recent comprehensive functional assessment of such individual conducted under subsection (c)(2) of this section;

(B) specifies, within any amount, duration, and scope limitations imposed on home and community care provided under the State plan, the home and community care to be provided to such individual under the plan, and indicates the individual's preferences for the types and providers of services; and

(C) may specify other services required by such individual.

An ICCP may also designate the specific providers (qualified to provide home and community care under the State plan) which will provide the home and community care described in subparagraph (B). Nothing in this section shall be construed as authorizing an ICCP or the State to restrict the specific persons or individuals (who are competent to provide home and community care under the State plan) who will provide the home and community care described in subparagraph (B).

(2) Qualified community care case manager defined

In this section, the term "qualified community care case manager" means a nonprofit or public agency or organization which--

(A) has experience or has been trained in establishing, and in periodically reviewing and revising, individual community care plans and in the provision of case management services to the elderly;

(B) is responsible for (i) assuring that home and community care covered under the State plan and specified in the ICCP is being provided, (ii) visiting each individual's home or community setting where care is being provided not less often than once every 90 days, and (iii) informing the elderly individual or primary caregiver on how to contact the case manager if service providers fail to properly provide services or other similar problems occur;

(C) in the case of a nonpublic agency, does not provide home and community care or nursing facility services and does not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, home and community care or nursing facility services;

(D) has procedures for assuring the quality of case management services that includes a peer review process;

(E) completes the ICCP in a timely manner and reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers; and

(F) meets such other standards, established by the Secretary, as to assure that--

(i) such a manager is competent to perform case management functions;

(ii) individuals whose home and community care they manage are not at risk of financial exploitation due to such a manager; and

(iii) meets such other standards as the State may establish.

The Secretary may waive the requirement of subparagraph (C) in the case of a nonprofit agency located in a rural area.

(3) Appeals process

Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals who disagree with the ICCP established.

(e) Ceiling on payment amounts and maintenance of effort

(1) Ceiling on payment amounts

Payments may not be made under [section 1396b\(a\)](#) of this title to a State for home and community care provided under this section in a quarter to the extent that the medical assistance for such care in the quarter exceeds 50 percent of the product of--

(A) the average number of individuals in the quarter receiving such care under this section;

(B) the average per diem rate of payment which the Secretary has determined (before the beginning of the quarter) will be payable under subchapter XVIII of this chapter (without regard to coinsurance) for extended care services to be provided in the State during such quarter; and

(C) the number of days in such quarter.

(2) Maintenance of effort

(A) Annual reports

As a condition for the receipt of payment under [section 1396b\(a\)](#) of this section with respect to medical assistance provided by a State for home and community care (other than a waiver under [section 1396n\(c\)](#) of this title and other than home health care services described in [section 1396d\(a\)\(7\)](#) of this title and personal care services specified under regulations under [section 1396d\(a\)\(23\)](#) of this title), the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1990) and in a format developed or approved by the Secretary, the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year.

(B) Reduction in payment if failure to maintain effort

If the amount reported under subparagraph (A) by a State with respect to a fiscal year is less than the amount reported under subparagraph (A) with respect to fiscal year 1989, the Secretary shall provide for a reduction in payments to the State under [section 1396b\(a\)](#) of this title in an amount equal to the difference between the amounts so reported.

(f) Minimum requirements for home and community care

(1) Requirements

Home and Community [\[FN1\]](#) care provided under this section must meet such requirements for individuals' rights and quality as are published or developed by the Secretary under subsection (k) of this section. Such requirements shall include--

(A) the requirement that individuals providing care are competent to provide such care; and

(B) the rights specified in paragraph (2).

(2) Specified rights

The rights specified in this paragraph are as follows:

(A) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

(B) The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities.

(C) The right to confidentiality of personal and clinical records.

(D) The right to privacy and to have one's property treated with respect.

(E) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

(F) The right to education or training for oneself and for members of one's family or household on the management of care.

(G) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual's ICCP.

(H) The right to be fully informed orally and in writing of the individual's rights.

(I) Guidelines for such minimum compensation for individuals providing such care as will assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

(J) Any other rights established by the Secretary.

(g) Minimum requirements for small community care settings

(1) Small community care settings defined

In this section, the term “small community care setting” means--

(A) a nonresidential setting that serves more than 2 and less than 8 individuals; or

(B) a residential setting in which more than 2 and less than 8 unrelated adults reside and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

(2) Minimum requirements

A small community care setting in which community care is provided under this section must--

(A) meet such requirements as are published or developed by the Secretary under subsection (k) of this section;

(B) meet the requirements of [paragraphs \(1\)\(A\), \(1\)\(C\), \(1\)\(D\), \(3\), and \(6\) of section 1396r\(c\)](#) of this title, to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting;

(D) meet any applicable State or local requirements regarding certification or licensure;

(E) meet any applicable State and local zoning, building, and housing codes, and State and local fire and safety regulations; and

(F) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents.

(h) Minimum requirements for large community care settings

(1) Large community care setting defined

In this section, the term “large community care setting” means--

(A) a nonresidential setting in which more than 8 individuals are served; or

(B) a residential setting in which more than 8 unrelated adults reside and in which personal services are provided in conjunction with residing in the setting in which home and community care under this section is provided.

(2) Minimum requirements

A large community care setting in which community care is provided under this section must--

(A) meet such requirements as are published or developed by the Secretary under subsection (k) of this section;

(B) meet the requirements of [paragraphs \(1\)\(A\), \(1\)\(C\), \(1\)\(D\), \(3\), and \(6\) of section 1396r\(c\)](#) of this title, to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives home and community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting; and

(D) meet the requirements of [paragraphs \(2\) and \(3\) of section 1396r\(d\)](#) (relating to administration and other matters) in the same manner as such requirements apply to nursing facilities under such section; except that, in applying the requirement of [section 1396r\(d\)\(2\)](#) of this title (relating to life safety code), the Secretary shall provide for the application of such life safety requirements (if any) that are appropriate to the setting.

(3) Disclosure of ownership and control interests and exclusion of repeated violators

A community care setting--

(A) must disclose persons with an ownership or control interest (including such persons as defined in [section 1320a-3\(a\)\(3\)](#) of this title) in the setting; and

(B) may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under this subchapter or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard or to have failed to meet the requirements of paragraph (2).

(i) Survey and certification process

(1) Certifications

(A) Responsibilities of the State

Under each State plan under this subchapter, the State shall be responsible for certifying the compliance of providers of home and community care and community care settings with the applicable requirements of subsections (f), (g) and (h) of this section. The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(B) Responsibilities of the Secretary

The Secretary shall be responsible for certifying the compliance of State providers of home and community care, and of State community care settings in which such care is provided, with the requirements of subsections (f), (g) and (h) of this section.

(C) Frequency of certifications

Certification of providers and settings under this subsection shall occur no less frequently than once every 12 months.

(2) Reviews of providers

(A) In general

The certification under this subsection with respect to a provider of home or community care must be based on a periodic review of the provider's performance in providing the care required under ICCP's in accordance with the requirements of subsection (f) of this section.

(B) Special reviews of compliance

Where the Secretary has reason to question the compliance of a provider of home or community care with any of the requirements of subsection (f) of this section, the Secretary may conduct a review of the provider and, on the basis of that review, make independent and binding determinations concerning the extent to which the provider meets such requirements.

(3) Surveys of community care settings

(A) In general

The certification under this subsection with respect to community care settings must be based on a survey. Such survey for such a setting must be conducted without prior notice to the setting. Any individual who notifies (or causes to be notified) a community care setting of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed \$2,000. The provisions of [section 1320a-7a](#) of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title. The Secretary shall review each State's procedures for scheduling and conducting such surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(B) Survey protocol

Surveys under this paragraph shall be conducted based upon a protocol which the Secretary has provided for under subsection (k) of this section.

(C) Prohibition of conflict of interest in survey team membership

A State and the Secretary may not use as a member of a survey team under this paragraph an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the community care setting being surveyed (or the person responsible for such setting) respecting compliance with the requirements of subsection (g) or (h) of this section or who has a personal or familial financial interest in the setting being surveyed.

(D) Validation surveys of community care settings

The Secretary shall conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the date of surveys conducted under subparagraph (A) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under subparagraph (A). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under subparagraph (B). If the State has determined that an individual setting meets the requirements of subsection (g) of this section, but the Secretary determines that the setting does not meet such requirements, the Secretary's determination as to the setting's noncompliance with such requirements is binding and supersedes that of the State survey.

(E) Special surveys of compliance

Where the Secretary has reason to question the compliance of a community care setting with any of the requirements of subsection (g) or (h) of this section, the Secretary may conduct a survey of the setting and, on the basis of that survey, make independent and binding determinations concerning the extent to which the setting meets such requirements.

(4) Investigation of complaints and monitoring of providers and settings

Each State and the Secretary shall maintain procedures and adequate staff to investigate complaints of violations of applicable requirements imposed on providers of community care or on community care settings under subsections (f), (g) and (h) of this section.

(5) Investigation of allegations of individual neglect and abuse and misappropriation of individual property

The State shall provide, through the agency responsible for surveys and certification of providers of home or community care and community care settings under this subsection, for a process for the receipt, review, and investigation of allegations of individual neglect and abuse (including injuries of unknown source) by individuals providing such care or in such setting and of misappropriation of individual property by such individuals. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused an individual receiving community care or misappropriated such individual's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that a person has neglected an individual receiving community care if the person demonstrates that such neglect was caused by factors beyond the control of the person. The State shall provide for public disclosure of findings under this paragraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings.

(6) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public--

- (i) information respecting all surveys, reviews, and certifications made under this subsection respecting providers of home or community care and community care settings, including statements of deficiencies,
- (ii) copies of cost reports (if any) of such providers and settings filed under this subchapter,
- (iii) copies of statements of ownership under [section 1320a-3](#) of this title, and

(iv) information disclosed under [section 1320a-5](#) of this title.

(B) Notices of substandard care

If a State finds that--

(i) a provider of home or community care has provided care of substandard quality with respect to an individual, the State shall make a reasonable effort to notify promptly (I) an immediate family member of each such individual and (II) individuals receiving home or community care from that provider under this subchapter, or

(ii) a community care setting is substandard, the State shall make a reasonable effort to notify promptly (I) individuals receiving community care in that setting, and (II) immediate family members of such individuals.

(C) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under [section 1396b\(q\)](#) of this title) with access to all information of the State agency responsible for surveys, reviews, and certifications under this subsection.

(j) Enforcement process for providers of community care

(1) State authority

(A) In general

If a State finds, on the basis of a review under subsection (i)(2) of this section or otherwise, that a provider of home or community care no longer meets the requirements of this section, the State may terminate the provider's participation under the State plan and may provide in addition for a civil money penalty. Nothing in this subparagraph shall be construed as restricting the remedies available to a State to remedy a provider's deficiencies. If the State finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A) for the period during which it finds that the provider was not in compliance with such requirements.

(B) Civil money penalty

(i) In general

Each State shall establish by law (whether statute or regulation) at least the following remedy: A civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty under subsection (i)(3)(A) of this section) may be applied to reimbursement of individuals for personal funds lost due to a failure of home or community care providers to meet the requirements of this section. The State also shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(ii) Deadline and guidance

Each State which elects to provide home and community care under this section must establish the civil money penalty remedy described in clause (i) applicable to all providers of community care covered under this section. The Secretary shall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedy; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedy.

(2) Secretarial authority

(A) For State providers

With respect to a State provider of home or community care, the Secretary shall have the authority and duties of a State under this subsection, except that the civil money penalty remedy described in subparagraph (C) shall be substituted for the civil money remedy described in paragraph (1)(B)(i).

(B) Other providers

With respect to any other provider of home or community care in a State, if the Secretary finds that a provider no longer meets a requirement of this section, the Secretary may terminate the provider's participation under the State plan and may provide, in addition, for a civil money penalty under subparagraph (C). If the Secretary finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C) for the period during which the Secretary finds that the provider was not in compliance with such requirements.

(C) Civil money penalty

If the Secretary finds on the basis of a review under subsection (i)(2) of this section or otherwise that a home or community care provider no longer meets the requirements of this section, the Secretary shall impose a civil money penalty in an amount not to exceed \$10,000 for each day of noncompliance. The provisions of [section 1320a-7a](#) of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title. The Secretary shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(k) Secretarial responsibilities

(1) Publication of interim requirements

(A) In general

The Secretary shall publish, by December 1, 1991, a proposed regulation that sets forth interim requirements, consistent with subparagraph (B), for the provision of home and community care and for community care settings, including--

(i) the requirements of subsection (c)(2) of this section (relating to comprehensive functional assessments, including the use of assessment instruments), of subsection (d)(2)(E) of this section (relating to qualifications for qualified case managers), of subsection (f) of this section (relating to minimum requirements for home and community care), of subsection (g) of this section (relating to minimum requirements for small community care settings), and of subsection (h) of this section (relating to minimum requirements for large community care settings) and

(ii) survey protocols (for use under subsection (i)(3)(A) of this section) which relate to such requirements.

(B) Minimum protections

Interim requirements under subparagraph (A) and final requirements under paragraph (2) shall assure, through methods other than reliance on State licensure processes, that individuals receiving home and community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings.

(2) Development of final requirements

The Secretary shall develop, by not later than October 1, 1992--

(A) final requirements, consistent with paragraph (1)(B), respecting the provision of appropriate, quality home and community care and respecting community care settings under this section, and including at least the requirements referred to in paragraph (1)(A)(i), and

(B) survey protocols and methods for evaluating and assuring the quality of community care settings.

The Secretary may, from time to time, revise such requirements, protocols, and methods.

(3) No delegation to states

The Secretary's authority under this subsection shall not be delegated to States.

(4) No prevention of more stringent requirements by States

Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary under this subsection.

(l) Waiver of Statewideness

States may waive the requirement of [section 1396a\(a\)\(1\)](#) of this title (related to Statewideness) for a program of home and community care under this section.

(m) Limitation on amount of expenditures as medical assistance

(1) Limitation on amount

The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, \$40,000,000, for fiscal year 1992, \$70,000,000, for fiscal year 1993, \$130,000,000, for fiscal year 1994, \$160,000,000, and for fiscal year 1995, \$180,000,000.

(2) Assurance of entitlement to service

A State which receives Federal medical assistance for expenditures for home and community care under this section must provide home and community care specified under the Individual Community Care Plan under subsection (d) of this section to individuals described in subsection (b) of this section for the duration of the election period, without regard to the

amount of funds available to the State under paragraph (1). For purposes of this paragraph, an election period is the period of 4 or more calendar quarters elected by the State, and approved by the Secretary, for the provision of home and community care under this section.

(3) Limitation on eligibility

The State may limit eligibility for home and community care under this section during an election period under paragraph (2) to reasonable classifications (based on age, degree of functional disability, and need for services).

(4) Allocation of medical assistance

The Secretary shall establish a limitation on the amount of Federal medical assistance available to any State during the State's election period under paragraph (2). The limitation under this paragraph shall take into account the limitation under paragraph (1) and the number of elderly individuals age 65 or over residing in such State in relation to the number of such elderly individuals in the United States during 1990. For purposes of the previous sentence, elderly individuals shall, to the maximum extent practicable, be low-income elderly individuals.

[FN1] So in original. Probably should not be capitalized.

§ 1396u. Community supported living arrangements services

(a) Community supported living arrangements services

In this subchapter, the term “community supported living arrangements services” means one or more of the following services meeting the requirements of subsection (h) of this section provided in a State eligible to provide services under this section (as defined in subsection (d) of this section) to assist a developmentally disabled individual (as defined in subsection (b) of this section) in activities of daily living necessary to permit such individual to live in the individual's own home, apartment, family home, or rental unit furnished in a community supported living arrangement setting:

- (1) Personal assistance.
- (2) Training and habilitation services (necessary to assist the individual in achieving increased integration, independence and productivity).
- (3) 24-hour emergency assistance (as defined by the Secretary).
- (4) Assistive technology.
- (5) Adaptive equipment.
- (6) Other services (as approved by the Secretary, except those services described in subsection (g) of this section).
- (7) Support services necessary to aid an individual to participate in community activities.

(b) “Developmentally disabled individual” defined

In this subchapter the term, [FN1] “developmentally disabled individual” means an individual who as defined by the Secretary is described within the term “mental retardation and related conditions” as defined in regulations as in effect on July 1,

1990, and who is residing with the individual's family or legal guardian in such individual's own home in which no more than 3 other recipients of services under this section are residing and without regard to whether or not such individual is at risk of institutionalization (as defined by the Secretary).

(c) Criteria for selection of participating States

The Secretary shall develop criteria to review the applications of States submitted under this section to provide community supported living arrangement services. The Secretary shall provide in such criteria that during the first 5 years of the provision of services under this section that no less than 2 and no more than 8 States shall be allowed to receive Federal financial participation for providing the services described in this section.

(d) Quality assurance

A State selected by the Secretary to provide services under this section shall in order to continue to receive Federal financial participation for providing services under this section be required to establish and maintain a quality assurance program, that provides that--

(1) the State will certify and survey providers of services under this section (such surveys to be unannounced and average at least 1 a year);

(2) the State will adopt standards for survey and certification that include--

(A) minimum qualifications and training requirements for provider staff;

(B) financial operating standards; and

(C) a consumer grievance process;

(3) the State will provide a system that allows for monitoring boards consisting of providers, family members, consumers, and neighbors;

(4) the State will establish reporting procedures to make available information to the public;

(5) the State will provide ongoing monitoring of the health and well-being of each recipient;

(6) the State will provide the services defined in subsection (a) of this section in accordance with an individual support plan (as defined by the Secretary in regulations); and

(7) the State plan amendment under this section shall be reviewed by the State Council on Developmental Disabilities established under section 125 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 [[42 U.S.C.A. § 15025](#)] and the protection and advocacy system established under subtitle C of that Act [[42 U.S.C.A. § 15041 et seq.](#)].

The Secretary shall not approve a quality assurance plan under this subsection and allow a State to continue to receive Federal financial participation under this section unless the State provides for public hearings on the plan prior to adoption and implementation of its plan under this subsection.

(e) Maintenance of effort

States selected by the Secretary to receive Federal financial participation to provide services under this section shall maintain current levels of spending for such services in order to be eligible to continue to receive Federal financial participation for the provision of such services under this section.

(f) Excluded services

No Federal financial participation shall be allowed for the provision of the following services under this section:

- (1) Room and board.
- (2) Cost of prevocational, vocational and supported employment.

(g) Waiver of requirements

The Secretary may waive such provisions of this subchapter as necessary to carry out the provisions of this section including the following requirements of this subchapter--

- (1) comparability of amount, duration, and scope of services; and
- (2) statewideness.

(h) Minimum protections

(1) Publication of interim and final requirements

(A) In general

The Secretary shall publish, by July 1, 1991, a regulation (that shall be effective on an interim basis pending the promulgation of final regulations), and by October 1, 1992, a final regulation, that sets forth interim and final requirements, respectively, consistent with subparagraph (B), to protect the health, safety, and welfare of individuals receiving community supported living arrangements services.

(B) Minimum protections

Interim and final requirements under subparagraph (A) shall assure, through methods other than reliance on State licensure processes or the State quality assurance programs under subsection (d) of this section, that--

- (i) individuals receiving community supported living arrangements services are protected from neglect, physical and sexual abuse, and financial exploitation;
- (ii) a provider of community supported living arrangements services may not use individuals who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual and shall take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual;
- (iii) individuals or entities delivering such services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and

(iv) individuals or entities delivering such services to clients, or relatives of such individuals, are prohibited from being named beneficiaries of life insurance policies purchased by (or on behalf of) such clients.

(2) Specified remedies

If the Secretary finds that a provider has not met an applicable requirement under subsection (h) of this section, the Secretary shall impose a civil money penalty in an amount not to exceed \$10,000 for each day of noncompliance. The provisions of [section 1320a-7a](#) of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(i) Treatment of funds

Any funds expended under this section for medical assistance shall be in addition to funds expended for any existing services covered under the State plan, including any waiver services for which an individual receiving services under this program is already eligible.

(j) Limitation on amounts of expenditures as medical assistance

The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, \$5,000,000, for fiscal year 1992, \$10,000,000, for fiscal year 1993, \$20,000,000, for fiscal year 1994, \$30,000,000, for fiscal year 1995, \$35,000,000, and for fiscal years thereafter such sums as provided by Congress.

[\[FN1\]](#) So in original. The comma probably should precede “the term”.

[§ 1396u-1. Assuring coverage for certain low-income families](#)

(a) References to subchapter IV-A are references to pre-welfare-reform provisions

Subject to the succeeding provisions of this section, with respect to a State any reference in this subchapter (or any other provision of law in relation to the operation of this subchapter) to a provision of part A of subchapter IV of this chapter, or a State plan under such part (or a provision of such a plan), including income and resource standards and income and resource methodologies under such part or plan, shall be considered a reference to such a provision or plan as in effect as of July 16, 1996, with respect to the State.

(b) Application of pre-welfare-reform eligibility criteria

(1) In general

For purposes of this subchapter, subject to paragraphs (2) and (3), in determining eligibility for medical assistance--

(A) an individual shall be treated as receiving aid or assistance under a State plan approved under part A of subchapter IV of this chapter only if the individual meets--

(i) the income and resource standards for determining eligibility under such plan, and

(ii) the eligibility requirements of such plan under [subsections \(a\)](#) through [\(c\) of section 606](#) of this title and [section 607\(a\)](#) of this title,

as in effect as of July 16, 1996; and

(B) the income and resource methodologies under such plan as of such date shall be used in the determination of whether any individual meets income and resource standards under such plan.

(2) State option

For purposes of applying this section, a State--

(A) may lower its income standards applicable with respect to part A of subchapter IV of this chapter, but not below the income standards applicable under its State plan under such part on May 1, 1988;

(B) may increase income or resource standards under the State plan referred to in paragraph (1) over a period (beginning after July 16, 1996) by a percentage that does not exceed the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average) over such period; and

(C) may use income and resource methodologies that are less restrictive than the methodologies used under the State plan under such part as of July 16, 1996.

(3) Option to terminate medical assistance for failure to meet work requirement

(A) Individuals receiving cash assistance under TANF

In the case of an individual who--

(i) is receiving cash assistance under a State program funded under part A of subchapter IV of this chapter,

(ii) is eligible for medical assistance under this subchapter on a basis not related to [section 1396a\(1\)](#) of this title, and

(iii) has the cash assistance under such program terminated pursuant to [section 607\(e\)\(1\)\(B\)](#) of this title (as in effect on or after the welfare reform effective date) because of refusing to work,

the State may terminate such individual's eligibility for medical assistance under this subchapter until such time as there no longer is a basis for the termination of such cash assistance because of such refusal.

(B) Exception for children

Subparagraph (A) shall not be construed as permitting a State to terminate medical assistance for a minor child who is not the head of a household receiving assistance under a State program funded under part A of subchapter IV of this chapter.

(c) Treatment for purposes of transitional coverage provisions

(1) Transition in the case of child support collections

The provisions of [section 606\(h\)](#) of this title (as in effect on July 16, 1996) shall apply, in relation to this subchapter, with respect to individuals (and families composed of individuals) who are described in subsection (b)(1)(A) of this section, in

the same manner as they applied before such date with respect to individuals who became ineligible for aid to families with dependent children as a result (wholly or partly) of the collection of child or spousal support under part D of subchapter IV of this chapter.

(2) Transition in the case of earnings from employment

For continued medical assistance in the case of individuals (and families composed of individuals) described in subsection (b)(1)(A) of this section who would otherwise become ineligible because of hours or income from employment, see [sections 1396r-6](#) and [1396a\(e\)\(1\)](#) of this title.

(d) Waivers

In the case of a waiver of a provision of part A of subchapter IV of this chapter in effect with respect to a State as of July 16, 1996, or which is submitted to the Secretary before August 22, 1996 and approved by the Secretary on or before July 1, 1997, if the waiver affects eligibility of individuals for medical assistance under this subchapter, such waiver may (but need not) continue to be applied, at the option of the State, in relation to this subchapter after the date the waiver would otherwise expire.

(e) State option to use 1 application form

Nothing in this section, or part A of subchapter IV of this chapter, shall be construed as preventing a State from providing for the same application form for assistance under a State program funded under part A of subchapter IV of this chapter (on or after the welfare reform effective date) and for medical assistance under this subchapter.

(f) Additional rules of construction

(1) With respect to the reference in [section 1396a\(a\)\(5\)](#) of this title to a State plan approved under part A of subchapter IV of this chapter, a State may treat such reference as a reference either to a State program funded under such part (as in effect on and after the welfare reform effective date) or to the State plan under this subchapter.

(2) Any reference in [section 1396a\(a\)\(55\)](#) of this title to a State plan approved under part A of subchapter IV of this chapter shall be deemed a reference to a State program funded under such part.

(3) In applying [section 1396b\(f\)](#) of this title, the applicable income limitation otherwise determined shall be subject to increase in the same manner as income or resource standards of a State may be increased under subsection (b)(2)(B) of this section.

(g) Relation to other provisions

The provisions of this section shall apply notwithstanding any other provision of this chapter.

(h) Transitional increased Federal matching rate for increased administrative costs

(1) In general

Subject to the succeeding provisions of this subsection, the Secretary shall provide that with respect to administrative expenditures described in paragraph (2) the per centum specified in [section 1396b\(a\)\(7\)](#) of this title shall be increased to such percentage as the Secretary specifies.

(2) Administrative expenditures described

The administrative expenditures described in this paragraph are expenditures described in [section 1396b\(a\)\(7\)](#) of this title that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs of eligibility determinations that (but for the enactment of this section) would not be incurred.

(3) Limitation

The total amount of additional Federal funds that are expended as a result of the application of this subsection for the period beginning with fiscal year 1997 shall not exceed \$500,000,000. In applying this paragraph, the Secretary shall ensure the equitable distribution of additional funds among the States.

(i) Welfare reform effective date

In this section, the term “welfare reform effective date” means the effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (as specified in section 116 of such Act).

§ 1396u-2. Provisions relating to managed care

(a) State option to use managed care

(1) Use of medicaid managed care organizations and primary care case managers

(A) In general

Subject to the succeeding provisions of this section, and notwithstanding [paragraph \(1\)](#), [\(10\)\(B\)](#), or [\(23\)\(A\) of section 1396a\(a\)](#) of this title, a State--

(i) may require an individual who is eligible for medical assistance under the State plan under this subchapter to enroll with a managed care entity as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if--

(I) the entity and the contract with the State meet the applicable requirements of this section and [section 1396b\(m\)](#) or [section 1396d\(t\)](#) of this title, and

(II) the requirements described in the succeeding paragraphs of this subsection are met; and

(ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

(B) Definition of managed care entity

In this section, the term “managed care entity” means--

(i) a medicaid managed care organization, as defined in [section 1396b\(m\)\(1\)\(A\)](#) of this title, that provides or arranges for services for enrollees under a contract pursuant to [section 1396b\(m\)](#) of this title; and

(ii) a primary care case manager, as defined in [section 1396d\(t\)\(2\)](#) of this title.

(2) Special rules

(A) Exemption of certain children with special needs

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age who--

- (i) is eligible for supplemental security income under subchapter XVI of this chapter;
- (ii) is described in [section 701\(a\)\(1\)\(D\)](#) of this title;
- (iii) is described in [section 1396a\(e\)\(3\)](#) of this title;
- (iv) is receiving foster care or adoption assistance under part E of subchapter IV of this chapter; or
- (v) is in foster care or otherwise in an out-of-home placement.

(B) Exemption of medicare beneficiaries

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in [section 1396d\(p\)\(1\)](#) of this title) or an individual otherwise eligible for benefits under subchapter XVIII of this chapter.

(C) Indian enrollment

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 ([25 U.S.C. 1603\(c\)](#)) unless the entity is one of the following (and only if such entity is participating under the plan):

- (i) The Indian Health Service.
- (ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act ([25 U.S.C. 450 et seq.](#)) [FN1].
- (iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act ([25 U.S.C. 1601 et seq.](#)).

(3) Choice of coverage

(A) In general

A State must permit an individual to choose a managed care entity from not less than two such entities that meet the applicable requirements of this section, and of [section 1396b\(m\)](#) or [section 1396d\(t\)](#) of this title.

(B) State option

At the option of the State, a State shall be considered to meet the requirements of subparagraph (A) in the case of an individual residing in a rural area, if the State requires the individual to enroll with a managed care entity if such entity--

(i) permits the individual to receive such assistance through not less than two physicians or case managers (to the extent that at least two physicians or case managers are available to provide such assistance in the area), and

(ii) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

(C) Treatment of certain county-operated health insuring organizations

A State shall be considered to meet the requirement of subparagraph (A) if--

(i) the managed care entity in which the individual is enrolled is a health-insuring organization which--

(I) first became operational prior to January 1, 1986, or

(II) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990) [[42 U.S.C.A. § 1396b](#) note], and

(ii) the individual is given a choice between at least two providers within such entity.

(4) Process for enrollment and termination and change of enrollment

As conditions under paragraph (1)(A)--

(A) In general

The State, enrollment broker (if any), and managed care entity shall permit an individual eligible for medical assistance under the State plan under this subchapter who is enrolled with the entity under this subchapter to terminate (or change) such enrollment--

(i) for cause at any time (consistent with [section 1396b\(m\)\(2\)\(A\)\(vi\)](#) of this title), and

(ii) without cause--

(I) during the 90-day period beginning on the date the individual receives notice of such enrollment, and

(II) at least every 12 months thereafter.

(B) Notice of termination rights

The State shall provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions. Such notice shall be provided at least 60 days before each annual enrollment opportunity described in subparagraph (A)(ii)(II).

(C) Enrollment priorities

In carrying out paragraph (1)(A), the State shall establish a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

(D) Default enrollment process

In carrying out paragraph (1)(A), the State shall establish a default enrollment process--

(i) under which any such individual who does not enroll with a managed care entity during the enrollment period specified by the State shall be enrolled by the State with such an entity which has not been found to be out of substantial compliance with the applicable requirements of this section and of [section 1396b\(m\)](#) or [section 1396d\(t\)](#) of this title; and

(ii) that takes into consideration--

(I) maintaining existing provider-individual relationships or relationships with providers that have traditionally served beneficiaries under this subchapter; and

(II) if maintaining such provider relationships is not possible, the equitable distribution of such individuals among qualified managed care entities available to enroll such individuals, consistent with the enrollment capacities of the entities.

(5) Provision of information

(A) Information in easily understood form

Each State, enrollment broker, or managed care entity shall provide all enrollment notices and informational and instructional materials relating to such an entity under this subchapter in a manner and form which may be easily understood by enrollees and potential enrollees of the entity who are eligible for medical assistance under the State plan under this subchapter.

(B) Information to enrollees and potential enrollees

Each managed care entity that is a medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:

(i) Providers

The identity, locations, qualifications, and availability of health care providers that participate with the organization.

(ii) Enrollee rights and responsibilities

The rights and responsibilities of enrollees.

(iii) Grievance and appeal procedures

The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service.

(iv) Information on covered items and services

All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization. Each managed care entity that is a primary care case manager shall, upon request, make available to enrollees and potential enrollees in the organization's service area the information described in clause (iii).

(C) Comparative information

A State that requires individuals to enroll with managed care entities under paragraph (1)(A) shall annually (and upon request) provide, directly or through the managed care entity, to such individuals a list identifying the managed care entities that are (or will be) available and information (presented in a comparative, chart-like form) relating to the following for each such entity offered:

(i) Benefits and cost-sharing

The benefits covered and cost-sharing imposed by the entity.

(ii) Service area

The service area of the entity.

(iii) Quality and performance

To the extent available, quality and performance indicators for the benefits under the entity.

(D) Information on benefits not covered under managed care arrangement

A State, directly or through managed care entities, shall, on or before an individual enrolls with such an entity under this subchapter, inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under this subchapter but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.

(b) Beneficiary protections

(1) Specification of benefits

Each contract with a managed care entity under [section 1396b\(m\)](#) of this title or under [section 1396d\(t\)\(3\)](#) of this title shall specify the benefits the provision (or arrangement) for which the entity is responsible.

(2) Assuring coverage to emergency services

(A) In general

Each contract with a medicaid managed care organization under [section 1396b\(m\)](#) of this title and each contract with a primary care case manager under [section 1396d\(t\)\(3\)](#) of this title shall require the organization or manager--

(i) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager, and

(ii) to comply with guidelines established under [section 1395w-22](#) of this title (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to Medicare+Choice plans offered under part C of subchapter XVIII of this chapter.

The requirement under clause (ii) shall first apply 30 days after the date of promulgation of the guidelines referred to in such clause.

(B) "Emergency services" defined

In subparagraph (A)(i), the term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that--

(i) are furnished by a provider that is qualified to furnish such services under this subchapter, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

(C) "Emergency medical condition" defined

In subparagraph (B)(ii), the term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in--

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(D) Emergency services furnished by non-contract providers

Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this subchapter other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

(3) Protection of enrollee-provider communications

(A) In general

Subject to subparagraphs (B) and (C), under a contract under [section 1396b\(m\)](#) of this title a medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

(B) Construction

Subparagraph (A) shall not be construed as requiring a medicaid managed care organization to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization--

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization adopts a change in policy regarding such a counseling or referral service.

Nothing in this subparagraph shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974 [[29 U.S.C.A. § 1001 et seq.](#)].

(C) "Health care professional" defined

For purposes of this paragraph, the term "health care professional" means a physician (as defined in [section 1395x\(r\)](#) of this title) or other health care professional if coverage for the professional's services is provided under the contract referred to in subparagraph (A) for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) Grievance procedures

Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this subchapter, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

(5) Demonstration of adequate capacity and services

Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization--

(A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and

(B) maintains a sufficient number, mix, and geographic distribution of providers of services.

(6) Protecting enrollees against liability for payment

Each medicaid managed care organization shall provide that an individual eligible for medical assistance under the State plan under this subchapter who is enrolled with the organization may not be held liable--

(A) for the debts of the organization, in the event of the organization's insolvency,

(B) for services provided to the individual--

(i) in the event of the organization failing to receive payment from the State for such services; or

(ii) in the event of a health care provider with a contractual, referral, or other arrangement with the organization failing to receive payment from the State or the organization for such services, or

(C) for payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the organization in excess of the amount that would be owed by the individual if the organization had directly provided the services.

(7) Antidiscrimination

A medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

(8) Compliance with certain maternity and mental health requirements

Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of Title XXVII of the Public Health Service Act [[42 U.S.C.A. § 300gg-4 et seq.](#)] insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.

(c) Quality assurance standards

(1) Quality assessment and improvement strategy

(A) In general

If a State provides for contracts with medicaid managed care organizations under [section 1396b\(m\)](#) of this title, the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following:

(i) Access standards

Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.

(ii) Other measures

Examination of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards).

(iii) Monitoring procedures

Procedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees that reflect the full spectrum of populations enrolled under the contract and that includes requirements for provision of quality assurance data to the State using the data and information set that the Secretary has specified for use under part C of subchapter XVIII of this chapter or such alternative data as the Secretary approves, in consultation with the State.

(iv) Periodic review

Regular, periodic examinations of the scope and content of the strategy.

(B) Standards

The strategy developed under subparagraph (A) shall be consistent with standards that the Secretary first establishes within 1 year after August 5, 1997. Such standards shall not preempt any State standards that are more stringent than such standards. Guidelines relating to quality assurance that are applied under [section 1396n\(b\)\(2\)](#) of this title shall apply under this subsection until the effective date of standards for quality assurance established under this subparagraph.

(C) Monitoring

The Secretary shall monitor the development and implementation of strategies under subparagraph (A).

(D) Consultation

The Secretary shall conduct activities under subparagraphs (B) and (C) in consultation with the States.

(2) External independent review of managed care activities

(A) Review of contracts

(i) In general

Each contract under [section 1396b\(m\)](#) of this title with a medicaid managed care organization shall provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract. The requirement for such a review shall not apply until after the date that the Secretary establishes the identification method described in clause (ii).

(ii) Qualifications of reviewer

The Secretary, in consultation with the States, shall establish a method for the identification of entities that are qualified to conduct reviews under clause (i).

(iii) Use of protocols

The Secretary, in coordination with the National Governors' Association, shall contract with an independent quality review organization (such as the National Committee for Quality Assurance) to develop the protocols to be used in external independent reviews conducted under this paragraph on and after January 1, 1999.

(iv) Availability of results

The results of each external independent review conducted under this subparagraph shall be available to participating health care providers, enrollees, and potential enrollees of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

(B) Nonduplication of accreditation

A State may provide that, in the case of a medicaid managed care organization that is accredited by a private independent entity (such as those described in [section 1395w-22\(e\)\(4\)](#) of this title) or that has an external review conducted under [section 1395w-22\(e\)\(3\)](#) of this title, the external review activities conducted under subparagraph (A) with respect to the organization shall not be duplicative of review activities conducted as part of the accreditation process or the external review conducted under such section.

(C) Deemed compliance for medicare managed care organizations

At the option of a State, the requirements of subparagraph (A) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under [section 1395mm](#) of this title or a Medicare+Choice organization with a contract in effect under part C of subchapter XVIII of this chapter [[42 U.S.C.A. § 1395w-21 et seq.](#)] and the organization has had a contract in effect under [section 1396b\(m\)](#) of this title at least during the previous 2-year period.

(d) Protections against fraud and abuse

(1) Prohibiting affiliations with individuals debarred by Federal agencies

(A) In general

A managed care entity may not knowingly--

- (i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity, or
- (ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

(B) Effect of noncompliance

If a State finds that a managed care entity is not in compliance with clause (i) or (ii) of subparagraph (A), the State--

- (i) shall notify the Secretary of such noncompliance;
- (ii) may continue an existing agreement with the entity unless the Secretary (in consultation with the Inspector General

of the Department of Health and Human Services) directs otherwise; and

(iii) may not renew or otherwise extend the duration of an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

(C) Persons described

A person is described in this subparagraph if such person--

(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to [Executive Order No. 12549](#) or under guidelines implementing such order; or

(ii) is an affiliate (as defined in such Regulation) of a person described in clause (i).

(2) Restrictions on marketing

(A) Distribution of materials

(i) In general

A managed care entity, with respect to activities under this subchapter, may not distribute directly or through any agent or independent contractor marketing materials within any State--

(I) without the prior approval of the State, and

(II) that contain false or materially misleading information.

The requirement of subclause (I) shall not apply with respect to a State until such date as the Secretary specifies in consultation with such State.

(ii) Consultation in review of market materials

In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

(B) Service market

A managed care entity shall distribute marketing materials to the entire service area of such entity covered under the contract under [section 1396b\(m\)](#) or [section 1396d\(t\)\(3\)](#) of this title.

(C) Prohibition of tie-ins

A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

(D) Prohibiting marketing fraud

Each managed care entity shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

(E) Prohibition of “cold-call” marketing

Each managed care entity shall not, directly or indirectly, conduct door-to-door, telephonic, or other “cold-call” marketing of enrollment under this subchapter.

(3) State conflict-of-interest safeguards in medicaid risk contracting

A medicaid managed care organization may not enter into a contract with any State under [section 1396b\(m\)](#) of this title unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in subsection (a)(4)(C)(ii) of this section that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act ([41 U.S.C. 423](#)), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

(4) Use of unique physician identifier for participating physicians

Each medicaid managed care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this title to have a unique identifier in accordance with the system established under [section 1320d-2\(b\)](#) of this title.

(e) Sanctions for noncompliance

(1) Use of intermediate sanctions by the State to enforce requirements

(A) In general

A State may not enter into or renew a contract under [section 1396b\(m\)](#) of this title unless the State has established intermediate sanctions, which may include any of the types described in paragraph (2), other than the termination of a contract with a medicaid managed care organization, which the State may impose against a medicaid managed care organization with such a contract, if the organization--

(i) fails substantially to provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;

(ii) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this subchapter;

(iii) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this subchapter, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished--

(I) to the Secretary or the State under this subchapter; or

(II) to an enrollee, potential enrollee, or a health care provider under such subchapter; or

(v) fails to comply with the applicable requirements of [section 1396b\(m\)\(2\)\(A\)\(x\)](#) of this title.

The State may also impose such intermediate sanction against a managed care entity if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of subsection (d)(2)(A)(i)(II) of this section.

(B) Rule of construction

Clause (i) of subparagraph (A) shall not apply to the provision of abortion services, except that a State may impose a sanction on any medicaid managed care organization that has a contract to provide abortion services if the organization does not provide such services as provided for under the contract.

(2) Intermediate sanctions

The sanctions described in this paragraph are as follows:

(A) Civil money penalties as follows:

(i) Except as provided in clause (ii), (iii), or (iv), not more than \$25,000 for each determination under paragraph (1)(A).

(ii) With respect to a determination under clause (iii) or (iv)(I) of paragraph (1)(A), not more than \$100,000 for each such determination.

(iii) With respect to a determination under paragraph (1)(A)(ii), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

(iv) Subject to clause (ii), with respect to a determination under paragraph (1)(A)(iii), \$15,000 for each individual not enrolled as a result of a practice described in such subsection.

(B) The appointment of temporary management--

(i) to oversee the operation of the medicaid managed care organization upon a finding by the State that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees; or

(ii) to assure the health of the organization's enrollees, if there is a need for temporary management while--

(I) there is an orderly termination or reorganization of the organization; or

(II) improvements are made to remedy the violations found under paragraph (1),

except that temporary management under this subparagraph may not be terminated until the State has determined that the medicaid managed care organization has the capability to ensure that the violations shall not recur.

(C) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

(D) Suspension or default of all enrollment of individuals under this subchapter after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of [section 1396b\(m\)](#) of this title or this section.

(E) Suspension of payment to the entity under this subchapter for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) Treatment of chronic substandard entities

In the case of a medicaid managed care organization which has repeatedly failed to meet the requirements of [section 1396b\(m\)](#) of this title and this section, the State shall (regardless of what other sanctions are provided) impose the sanctions described in subparagraphs (B) and (C) of paragraph (2).

(4) Authority to terminate contract

(A) In general

In the case of a managed care entity which has failed to meet the requirements of this part or a contract under [section 1396b\(m\)](#) or [1396d\(t\)\(3\)](#) of this title, the State shall have the authority to terminate such contract with the entity and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this subchapter other than through a managed care entity).

(B) Availability of hearing prior to termination of contract

A State may not terminate a contract with a managed care entity under subparagraph (A) unless the entity is provided with a hearing prior to the termination.

(C) Notice and right to disenroll in cases of termination hearing

A State may--

(i) notify individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing, and

(ii) in the case of such an entity, permit such enrollees to disenroll immediately with the entity without cause.

(5) Other protections for managed care entities against sanctions imposed by State

Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in paragraph (2)(B).

(f) Timeliness of payment

A contract under [section 1396b\(m\)](#) of this title with a medicaid managed care organization shall provide that the organiza-

tion shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this subchapter who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in [section 1396a\(a\)\(37\)\(A\)](#) of this title, unless the health care provider and the organization agree to an alternate payment schedule.

(g) Identification of patients for purposes of making DSH payments

Each contract with a managed care entity under [section 1396b\(m\)](#) of this title or under [section 1396d\(t\)\(3\)](#) of this title shall require the entity either--

- (1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying [sections 1395ww\(d\)\(5\)\(F\)](#) and [1396r-4](#) of this title; or
- (2) to include a sponsorship code in the identification card issued to individuals covered under this subchapter in order that a hospital may identify a patient as being entitled to benefits under this subchapter.

(h) Special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities

- (1) Enrollee option to select an indian health care provider as primary care provider

In the case of a non-Indian Medicaid managed care entity that--

(A) has an Indian enrolled with the entity; and

(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under [section 1396b\(m\)](#) of this title or under [section 1396d\(t\)\(3\)](#) of this title shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

- (2) Assurance of payment to Indian health care providers for provision of covered services

Each contract with a managed care entity under [section 1396b\(m\)](#) of this title or under [section 1396d\(t\)\(3\)](#) of this title shall require any such entity, as a condition of receiving payment under such contract, to satisfy the following requirements:

(A) Demonstration of access to Indian health care providers and application of alternative payment arrangements

Subject to subparagraph (C), to--

- (i) demonstrate that the number of Indian health care providers that are participating providers with respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those Indian enrollees who are eligible to receive services from such providers; and
- (ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered Medicaid managed care services provided to those Indian enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which

the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

The Secretary shall establish procedures for applying the requirements of clause (i) in States where there are no or few Indian health providers.

(B) Prompt payment

To agree to make prompt payment (consistent with rule for prompt payment of providers under section 1396u-2(f) of this title) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (C) applies, that the entity is required to pay in accordance with that subparagraph.

(C) Application of special payment requirements for Federally-qualified health centers and for services provided by certain Indian health care providers

(i) Federally-qualified health centers

(I) Managed care entity payment requirement

To agree to pay any Indian health care provider that is a federally-qualified health center under this subchapter but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.

(II) Continued application of State requirement to make supplemental payment

Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of [section 1396a\(bb\)\(5\)](#) of this title regarding the State plan requirement to make any supplemental payment due under such section to a federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless of whether the federally-qualified health center is or is not a participating provider with the entity).

(ii) Payment rate for services provided by certain Indian health care providers

If the amount paid by a managed care entity to an Indian health care provider that is not a federally-qualified health center for services provided by the provider to an Indian enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian health care provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

(D) Construction

Nothing in this paragraph shall be construed as waiving the application of [section 1396a\(a\)\(30\)\(A\)](#) of this title (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

(3) Special rule for enrollment for Indian managed care entities

Regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities, an Indian Medi-

caid managed care entity may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

(4) Definitions

For purposes of this subsection:

(A) Indian health care provider

The term “Indian health care provider” means an Indian Health Program or an Urban Indian Organization.

(B) Indian Medicaid managed care entity

The term “Indian Medicaid managed care entity” means a managed care entity that is controlled (within the meaning of the last sentence of [section 1396b\(m\)\(1\)\(C\)](#) of this title) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(C) Non-Indian Medicaid managed care entity

The term “non-Indian Medicaid managed care entity” means a managed care entity that is not an Indian Medicaid managed care entity.

(D) Covered Medicaid managed care services

The term “covered Medicaid managed care services” means, with respect to an individual enrolled with a managed care entity, items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

(E) Medicaid managed care program

The term “Medicaid managed care program” means a program under [sections 1396b\(m\)](#), [1396d\(t\)](#), and 1396u-2 of this title and includes a managed care program operating under a waiver under [section 1396n\(b\)](#) or [1315](#) of this title or otherwise.

[\[FN1\]](#) So in original. Probably should read “([25 U.S.C. 450f et seq.](#))”.

[§ 1396u-3. State coverage of medicare cost-sharing for additional low-income medicare beneficiaries](#)

(a) In general

A State plan under this subchapter shall provide, under [section 1396a\(a\)\(10\)\(E\)\(iv\)](#) of this title and subject to the succeeding provisions of this section and through a plan amendment, for medical assistance for payment of the cost of medicare cost-sharing described in such section on behalf of all individuals described in such section (in this section referred to as “qualifying individuals”) who are selected to receive such assistance under subsection (b) of this section.

(b) Selection of qualifying individuals

A State shall select qualifying individuals, and provide such individuals with assistance, under this section consistent with the following:

(1) All qualifying individuals may apply

The State shall permit all qualifying individuals to apply for assistance during a calendar year.

(2) Selection on first-come, first-served basis

(A) In general

For each calendar year (beginning with 1998), from (and to the extent of) the amount of the allocation under subsection (c) of this section for the State for the fiscal year ending in such calendar year, the State shall select qualifying individuals who apply for the assistance in the order in which they apply.

(B) Carryover

For calendar years after 1998, the State shall give preference to individuals who were provided such assistance (or other assistance described in [section 1396a\(a\)\(10\)\(E\)](#) of this title) in the last month of the previous year and who continue to be (or become) qualifying individuals.

(3) Limit on number of individuals based on allocation

The State shall limit the number of qualifying individuals selected with respect to assistance in a calendar year so that the aggregate amount of such assistance provided to such individuals in such year is estimated to be equal to (but not exceed) the State's allocation under subsection (c) of this section for the fiscal year ending in such calendar year.

(4) Receipt of assistance during duration of year

If a qualifying individual is selected to receive assistance under this section for a month in a year, the individual is entitled to receive such assistance for the remainder of the year if the individual continues to be a qualifying individual. The fact that an individual is selected to receive assistance under this section at any time during a year does not entitle the individual to continued assistance for any succeeding year.

(c) Allocation

(1) Total allocation

The total amount available for allocation under this section for--

(A) fiscal year 1998 is \$200,000,000;

(B) fiscal year 1999 is \$250,000,000;

(C) fiscal year 2000 is \$300,000,000;

(D) fiscal year 2001 is \$350,000,000; and

(E) each of fiscal years 2002 and 2003 is \$400,000,000.

(2) Allocation to States

The Secretary shall provide for the allocation of the total amount described in paragraph (1) for a fiscal year, among the States that executed a plan amendment in accordance with subsection (a) of this section, based upon the Secretary's estimate of the ratio of--

(A) an amount equal to the total number of individuals described in [section 1396a\(a\)\(10\)\(E\)\(iv\)](#) of this title in the State; to

(B) the sum of the amounts computed under subparagraph (A) for all eligible States.

(d) Applicable FMAP

With respect to assistance described in [section 1396a\(a\)\(10\)\(E\)\(iv\)](#) of this title furnished in a State for calendar quarters in a calendar year--

(1) to the extent that such assistance does not exceed the State's allocation under subsection (c) of this section for the fiscal year ending in the calendar year, the Federal medical assistance percentage shall be equal to 100 percent; and

(2) to the extent that such assistance exceeds such allocation, the Federal medical assistance percentage is 0 percent.

(e) Limitation on entitlement

Except as specifically provided under this section, nothing in this subchapter shall be construed as establishing any entitlement of individuals described in [section 1396a\(a\)\(10\)\(E\)\(iv\)](#) of this title to assistance described in such section.

(f) Coverage of costs through part B of the medicare program

For each fiscal year, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under [section 1395t](#) of this title to the appropriate account in the Treasury that provides for payments under [section 1396b\(a\)](#) of this title with respect to medical assistance provided under this section, of an amount equivalent to the total of the amount of payments made under such section that is attributable to this section and such transfer shall be treated as an expenditure from such Trust Fund for purposes of [section 1395r](#) of this title.

(g) Special rules

(1) In general

With respect to each period described in paragraph (2), a State shall select qualifying individuals, subject to paragraph (3), and provide such individuals with assistance, in accordance with the provisions of this section as in effect with respect to calendar year 2003, except that for such purpose--

(A) references in the preceding subsections of this section to a year, whether fiscal or calendar, shall be deemed to be references to such period; and

(B) the total allocation amount under subsection (c) for such period shall be the amount described in paragraph (2) for

that period.

(2) Periods and total allocation amounts described

For purposes of this subsection--

(A) for the period that begins on January 1, 2004, and ends on September 30, 2004, the total allocation amount is \$300,000,000;

(B) for the period that begins on October 1, 2004, and ends on December 31, 2004, the total allocation amount is \$100,000,000;

(C) for the period that begins on January 1, 2005, and ends on September 30, 2005, the total allocation amount is \$300,000,000;

(D) for the period that begins on October 1, 2005, and ends on December 31, 2005, the total allocation amount is \$100,000,000;

(E) for the period that begins on January 1, 2006, and ends on September 30, 2006, the total allocation amount is \$300,000,000;

(F) for the period that begins on October 1, 2006, and ends on December 31, 2006, the total allocation amount is \$100,000,000;

(G) for the period that begins on January 1, 2007, and ends on September 30, 2007, the total allocation amount is \$300,000,000;

(H) for the period that begins on October 1, 2007, and ends on December 31, 2007, the total allocation amount is \$100,000,000;

(I) for the period that begins on January 1, 2008, and ends on September 30, 2008, the total allocation amount is \$315,000,000;

(J) for the period that begins on October 1, 2008, and ends on December 31, 2008, the total allocation amount is \$130,000,000;

(K) for the period that begins on January 1, 2009, and ends on September 30, 2009, the total allocation amount is \$350,000,000;

(L) for the period that begins on October 1, 2009, and ends on December 31, 2009, the total allocation amount is \$150,000,000;

(M) for the period that begins on January 1, 2010, and ends on September 30, 2010, the total allocation amount is \$462,500,000; and

(N) for the period that begins on October 1, 2010, and ends on December 31, 2010, the total allocation amount is \$165,000,000.

(3) Rules for periods that begin after January 1

For any specific period described in subparagraph (B), (D), (F), (H), (J), (L), or (N) of paragraph (2), the following applies:

(A) The specific period shall be treated as a continuation of the immediately preceding period in that calendar year for purposes of applying subsection (b)(2) and qualifying individuals who received assistance in the last month of such immediately preceding period shall be deemed to be selected for the specific period (without the need to complete an application for assistance for such period).

(B) The limit to be applied under subsection (b)(3) for the specific period shall be the same as the limit applied under such subsection for the immediately preceding period.

(C) The ratio to be applied under subsection (c)(2) for the specific period shall be the same as the ratio applied under such subsection for the immediately preceding period.

[§ 1396u-4. Program of all-inclusive care for the elderly \(PACE\)](#)

(a) State option

(1) In general

A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of subchapter XVIII of this chapter to be eligible to enroll under this section. In the case of an individual enrolled with a PACE program pursuant to such an election--

(A) the individual shall receive benefits under the plan solely through such program, and

(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

A State may establish a numerical limit on the number of individuals who may be enrolled in a PACE program under a PACE program agreement.

(2) PACE program defined

For purposes of this section, the term "PACE program" means a program of all-inclusive care for the elderly that meets the following requirements:

(A) Operation

The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) Comprehensive benefits

The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) Transition

In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

(3) PACE provider defined

(A) In general

For purposes of this section, the term “PACE provider” means an entity that--

- (i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under [section 501\(c\)\(3\) of Title 26](#), and
- (ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) Treatment of private, for-profit providers

Clause (i) of subparagraph (A) shall not apply--

- (i) to entities subject to a demonstration project waiver under subsection (h) of this section; and
- (ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

(4) PACE program agreement defined

For purposes of this section, the term “PACE program agreement” means, with respect to a PACE provider, an agreement, consistent with this section, [section 1395eee](#) of this title (if applicable), and regulations promulgated to carry out such sections, among the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

(5) PACE program eligible individual defined

For purposes of this section, the term “PACE program eligible individual” means, with respect to a PACE program, an individual who--

- (A) is 55 years of age or older;
- (B) subject to subsection (c)(4) of this section, is determined under subsection (c) of this section to require the level of care required under the State medicaid plan for coverage of nursing facility services;
- (C) resides in the service area of the PACE program; and
- (D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii) of this section.

(6) PACE protocol

For purposes of this section, the term “PACE protocol” means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

(7) PACE demonstration waiver program defined

For purposes of this section, the term “PACE demonstration waiver program” means a demonstration program under either

of the following sections (as in effect before the date of their repeal):

(A) Section 603(c) of the Social Security Amendments of 1983 ([Public Law 98-21](#)), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ([Public Law 99-272](#)).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 ([Public Law 99-509](#)).

(8) State administering agency defined

For purposes of this section, the term “State administering agency” means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this subchapter in the State) responsible for administering PACE program agreements under this section and [section 1395eee](#) of this title in the State.

(9) Trial period defined

(A) In general

For purposes of this section, the term “trial period” means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) Treatment of entities previously operating PACE demonstration waiver programs

Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) Regulations

For purposes of this section, the term “regulations” refers to interim final or final regulations promulgated under subsection (f) of this section to carry out this section and [section 1395eee](#) of this title.

(b) Scope of benefits; beneficiary safeguards

(1) In general

Under a PACE program agreement, a PACE provider shall--

(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum--

(i) all items and services covered under subchapter XVIII of this chapter (for individuals enrolled under [section 1395eee](#) of this title) and all items and services covered under this subchapter, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such subchapter or this subchapter, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) Quality assurance; patient safeguards

The PACE program agreement shall require the PACE provider to have in effect at a minimum--

(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this subchapter and Federal and State law designed for the protection of patients.

(3) Treatment of medicare services furnished by noncontract physicians and other entities

(A) Application of medicare advantage requirement with respect to medicare services furnished by noncontract physicians and other entities

[Section 1395w-22\(k\)\(1\)](#) of this title (relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under subchapter XVIII of this chapter) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

(B) Reference to related provision for noncontract providers of services

For the provision relating to limitations on balance billing against PACE providers for services covered under subchapter XVIII of this chapter furnished by noncontract providers of services, see [section 1395cc\(a\)\(1\)\(O\)](#) of this title.

(4) Reference to related provision for services covered under this subchapter but not under subchapter XVIII of this chapter

For provisions relating to limitations on payments to providers participating under the State plan under this subchapter that do not have a contract or other agreement with a PACE provider establishing payment amounts for services covered under such plan (but not under Subchapter XVIII of this chapter) when such services are furnished to enrollees of that PACE provider, see [section 1396a\(a\)\(67\)](#) of this title.

(c) Eligibility determinations

(1) In general

The determination of--

(A) whether an individual is a PACE program eligible individual shall be made under and in accordance with the PACE program agreement, and

(B) who is entitled to medical assistance under this subchapter shall be made (or who is not so entitled, may be made) by the State administering agency.

(2) Condition

An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

(3) Annual eligibility recertifications

(A) In general

Subject to subparagraph (B), the determination described in subsection (a)(5)(B) of this section for an individual shall be reevaluated at least annually.

(B) Exception

The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases in which the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

(4) Continuation of eligibility

An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) of this section if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

(5) Enrollment; disenrollment

(A) Voluntary disenrollment at any time

The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

(B) Limitations on disenrollment

(i) In general

Regulations promulgated by the Secretary under this section and [section 1395eee](#) of this title, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except--

(I) for nonpayment of premiums (if applicable) on a timely basis; or

(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

(ii) No disenrollment for noncompliant behavior

Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term “noncompliant behavior” includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

(iii) Timely review of proposed nonvoluntary disenrollment

A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

(d) Payments to PACE providers on a capitated basis

(1) In general

In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

(2) Capitation amount

The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under [section 1395eee](#) of this title for individuals who are enrolled in a PACE program under such section.

(e) PACE program agreement

(1) Requirement

(A) In general

The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, [section 1395eee](#) of this title, and regulations.

(B) Numerical limitation

(i) In general

The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed--

(I) 40 as of August 5, 1997, or

(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) Treatment of certain private, for-profit providers

The numerical limitation in clause (i) shall not apply to a PACE provider that--

(I) is operating under a demonstration project waiver under subsection (h) of this section, or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii) of this section.

(2) Service area and eligibility

(A) In general

A PACE program agreement for a PACE program--

(i) shall designate the service area of the program;

(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate, and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

(B) Service area overlap

In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE

program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

(3) Data collection; development of outcome measures.--

(A) Data collection

(i) In general

Under a PACE program agreement, the PACE provider shall--

(I) collect data;

(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

(III) submit to the Secretary and the State administering agency such reports as the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program.

(ii) Requirements during trial period

During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

(B) Development of outcome measures

Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

(4) Oversight

(A) Annual, close oversight during trial period

During the trial period (as defined in subsection (a)(9) of this section) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include--

(i) an onsite visit to the program site;

(ii) comprehensive assessment of a provider's fiscal soundness;

(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

(v) any other elements the Secretary or the State administering agency considers necessary or appropriate.

(B) Continuing oversight

After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) Disclosure

The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

(5) Termination of PACE provider agreements

(A) In general

Under regulations--

- (i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and
- (ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State administering agency, and enrollees.

(B) Causes for termination

In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that--

- (i) the Secretary or State administering agency determines that--
 - (I) there are significant deficiencies in the quality of care provided to enrolled participants; or
 - (II) the provider has failed to comply substantially with conditions for a program or provider under this section or [section 1395eee](#) of this title; and
- (ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

(C) Termination and transition procedures

An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C) of this section.

(6) Secretary's oversight; enforcement authority

(A) In general

Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

- (i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.
- (ii) Withhold some or all further payments under the PACE program agreement under this section or [section 1395eee](#) of this title with respect to PACE program services furnished by such provider until the deficiencies have been corrected.
- (iii) Terminate such agreement.

(B) Application of intermediate sanctions

Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in [section 1395w-27\(g\)\(2\)](#) of this title (or, for periods before January 1, 1999, [section 1395mm\(i\)\(6\)\(B\)](#) of this title) or 1396b(m)(5)(B) of this title in the case of violations by the provider of the type described in [section 1395w-27\(g\)\(1\)](#) of this title (or 1395mm(i)(6)(A) of this title for such periods) or 1396b(m)(5)(A) of this title, respectively (in relation to agreements, enrollees, and requirements under [section 1395eee](#) of this title or this section, respectively).

(7) Procedures for termination or imposition of sanctions

Under regulations, the provisions of [section 1395w-27\(h\)](#) of this title (or for periods before January 1, 1999, [section 1395mm\(i\)\(9\)](#) of this title) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part C of subchapter XVIII of this chapter (or for such periods an eligible organization under [section 1395mm](#) of this title).

(8) Timely consideration of applications for PACE program provider status

In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(f) Regulations

(1) In general

The Secretary shall issue interim final or final regulations to carry out this section and [section 1395eee](#) of this title.

(2) Use of PACE protocol.--

(A) In general

In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the

requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B) Flexibility

In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and [section 1395eee](#) of this title, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

- (i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.
- (ii) The delivery of comprehensive, integrated acute and long-term care services.
- (iii) The interdisciplinary team approach to care management and service delivery.
- (iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.
- (v) The assumption by the provider of full financial risk.

(C) Continuation of modifications or waivers of operational requirements under demonstration status

If a PACE program operating under demonstration authority has contractual or other operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1 [\[FN1\]](#) 2000, the Secretary (in close consultation with, and with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements so long as such arrangements are found by the Secretary and the State to be reasonably consistent with the objectives of the PACE program.

(3) Application of certain additional beneficiary and program protections

(A) In general

In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of subchapter XVIII of this chapter (or, for periods before January 1, 1999, [section 1395mm](#) of this title) and [sections 1396b\(m\)](#) and [1396u-2](#) of this title relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under [section 1395mm](#) of this title) and to medicaid managed organizations under prepaid capitation agreements under [section 1396b\(m\)](#) of this title.

(B) Considerations

In issuing such regulations, the Secretary shall--

- (i) take into account the differences between populations served and benefits provided under this section and under part C of subchapter XVIII of this chapter (or, for periods before January 1, 1999, [section 1395mm](#) of this title) and [section 1396b\(m\)](#) of this title;

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this subchapter or subchapter XVIII of this chapter.

(4) Construction

Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

(g) Waivers of requirements

With respect to carrying out a PACE program under this section, the following requirements of this subchapter (and regulations relating to such requirements) shall not apply:

(1) [Section 1396a\(a\)\(1\)](#) of this title, relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

(2) [Section 1396a\(a\)\(10\)](#) of this title, insofar as such section relates to comparability of services among different population groups.

(3) [Sections 1396a\(a\)\(23\)](#) and [1396n\(b\)\(4\)](#) of this title, relating to freedom of choice of providers under a PACE program.

(4) [Section 1396b\(m\)\(2\)\(A\)](#) of this title, insofar as it restricts a PACE provider from receiving prepaid capitation payments.

(5) Such other provisions of this subchapter that, as added or amended by the Balanced Budget Act of 1997, the Secretary determines are inapplicable to carrying out a PACE program under this section.

(h) Demonstration project for for-profit entities

(1) In general

In order to demonstrate the operation of a PACE program by a private, for-profit, entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) of this section that a PACE provider may not be a for-profit, private entity.

(2) Similar terms and conditions

(A) In general

Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) Numerical limitation

The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers

granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B) of this section.

(i) Post-eligibility treatment of income

A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under [section 1396n\(c\)](#) of this title.

(j) Miscellaneous provisions

Nothing in this section or [section 1395eee](#) of this title shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of subchapter XVIII of this chapter or eligible for medical assistance under this subchapter.

[FN1] So in original. Probably should be followed by a comma.

[§ 1396u-5. Special provisions relating to medicare prescription drug benefit](#)

(a) Requirements relating to medicare prescription drug low-income subsidies [FN1] medicare transitional prescription drug assistance, and medicare cost-sharing

As a condition of its State plan under this subchapter under [section 1396a\(a\)\(66\)](#) of this title and receipt of any Federal financial assistance under [section 1396b\(a\)](#) of this title subject to subsection (e) of this section, a State shall do the following:

(1) Information for transitional prescription drug assistance verification

The State shall provide the Secretary with information to carry out [section 1395w-141](#) of this title.

(2) Eligibility determinations for low-income subsidies

The State shall--

(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with [section 1395w-114](#) of this title;

(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

(C) otherwise provide the Secretary with such information as may be required to carry out part D, other than subpart 4 of part D, of subchapter XVIII of this chapter (including [section 1395w-114](#) of this title).

(3) Screening for eligibility, and enrollment of, beneficiaries for medicare cost-sharing

As part of making an eligibility determination required under paragraph (2) for an individual, the State shall make a determination of the individual's eligibility for medical assistance for any medicare cost-sharing described in [section 1396d\(p\)\(3\)](#) of this title, and, if the individual is eligible for any such medicare cost-sharing, offer enrollment to the individual under the State plan (or under a waiver of such plan).

(4) Consideration of data transmitted by the Social Security Administration for purposes of Medicare Savings Program

The State shall accept data transmitted under [section 1320b-14\(c\)\(3\)](#) of this title and act on such data in the same manner and in accordance with the same deadlines as if the data constituted an initiation of an application for benefits under the Medicare Savings Program (as defined for purposes of such section) that had been submitted directly by the applicant. The date of the individual's application for the low income subsidy program from which the data have been derived shall constitute the date of filing of such application for benefits under the Medicare Savings Program.

(b) Regular federal subsidy of administrative costs

The amounts expended by a State in carrying out subsection (a) of this section are expenditures reimbursable under the appropriate paragraph of [section 1396b](#) of this title.

(c) Federal assumption of medicaid prescription drug costs for dually eligible individuals

(1) Phased-down State contribution

(A) In general

Each of the 50 States and the District of Columbia for each month beginning with January 2006 shall provide for payment under this subsection to the Secretary of the product of--

- (i) the amount computed under paragraph (2)(A) for the State and month;
- (ii) the total number of full-benefit dual eligible individuals (as defined in paragraph (6)) for such State and month; and
- (iii) the factor for the month specified in paragraph (5).

(B) Form and manner of payment

Payment under subparagraph (A) shall be made in a manner specified by the Secretary that is similar to the manner in which State payments are made under an agreement entered into under [section 1395v](#) of this title, except that all such payments shall be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(C) Compliance

If a State fails to pay to the Secretary an amount required under subparagraph (A), interest shall accrue on such amount at the rate provided under [section 1396b\(d\)\(5\)](#) of this title. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under [section 1396b\(a\)](#) of this title subject to subsection (e) of this title, in accordance with the Federal Claims Collection Act of 1996 and applicable regulations.

(D) Data match

The Secretary shall perform such periodic data matches as may be necessary to identify and compute the number of full-benefit dual eligible individuals for purposes of computing the amount under subparagraph (A).

(2) Amount

(A) In general

The amount computed under this paragraph for a State described in paragraph (1) and for a month in a year is equal to--

(i) 1/12 of the product of--

(I) the base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals (as computed under paragraph (3)); and

(II) a proportion equal to 100 percent minus the Federal medical assistance percentage (as defined in [section 1396d\(b\)](#)) of this title applicable to the State for the fiscal year in which the month occurs; and

(ii) increased for each year (beginning with 2004 up to and including the year involved) by the applicable growth factor specified in paragraph (4) for that year.

(B) Notice

The Secretary shall notify each State described in paragraph (1) not later than October 15 before the beginning of each year (beginning with 2006) of the amount computed under subparagraph (A) for the State for that year.

(3) Base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals

(A) In general

For purposes of paragraph (2)(A), the “base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals” for a State is equal to the weighted average (as weighted under subparagraph (C)) of--

(i) the gross per capita medicaid expenditures for prescription drugs for 2003, determined under subparagraph (B); and

(ii) the estimated actuarial value of prescription drug benefits provided under a capitated managed care plan per full-benefit dual eligible individual for 2003, as determined using such data as the Secretary determines appropriate.

(B) Gross per capita medicaid expenditures for prescription drugs

(i) In general

The gross per capita medicaid expenditures for prescription drugs for 2003 under this subparagraph is equal to the expenditures, including dispensing fees, for the State under this subchapter during 2003 for covered outpatient drugs, determined per full-benefit-dual-eligible-individual for such individuals not receiving medical assistance for such drugs through a medicaid managed care plan.

(ii) Determination

In determining the amount under clause (i), the Secretary shall--

(I) use data from the Medicaid Statistical Information System (MSIS) and other available data;

(II) exclude expenditures attributable to covered outpatient prescription drugs that are not covered part D drugs (as defined in [section 1395w-102\(e\)](#) of this title, including drugs described in [subparagraph \(K\) of section 1396r-8\(d\)\(2\)](#) of this title); and

(III) reduce such expenditures by the product of such portion and the adjustment factor (described in clause (iii)).

(iii) Adjustment factor

The adjustment factor described in this clause for a State is equal to the ratio for the State for 2003 of--

(I) aggregate payments under agreements under [section 1396r-8](#) of this title; to

(II) the gross expenditures under this subchapter for covered outpatient drugs referred to in clause (i).

Such factor shall be determined based on information reported by the State in the medicaid financial management reports (form CMS-64) for the 4 quarters of calendar year 2003 and such other data as the Secretary may require.

(C) Weighted average

The weighted average under subparagraph (A) shall be determined taking into account--

(i) with respect to subparagraph (A)(i), the average number of full-benefit dual eligible individuals in 2003 who are not described in clause (ii); and

(ii) with respect to subparagraph (A)(ii), the average number of full-benefit dual eligible individuals in such year who received in 2003 medical assistance for covered outpatient drugs through a medicaid managed care plan.

(4) Applicable growth factor

The applicable growth factor under this paragraph for--

(A) each of 2004, 2005, and 2006, is the average annual percent change (to that year from the previous year) of the per capita amount of prescription drug expenditures (as determined based on the most recent National Health Expenditure projections for the years involved); and

(B) a succeeding year, is the annual percentage increase specified in [section 1395w-102\(b\)\(6\)](#) of this title for the year.

(5) Factor

The factor under this paragraph for a month--

(A) in 2006 is 90 percent;

(B) in 2007 is 88 1/3 percent;

(C) in 2008 is 86 2/3 percent;

(D) in 2009 is 85 percent;

(E) in 2010 is 83 1/3 percent;

(F) in 2011 is 81 2/3 percent;

(G) in 2012 is 80 percent;

(H) in 2013 is 78 1/3 percent;

(I) in 2014 is 76 2/3 percent; or

(J) after December 2014, is 75 percent.

(6) Full-benefit dual eligible individual defined

(A) In general

For purposes of this section, the term “full-benefit dual eligible individual” means for a State for a month an individual who--

(i) has coverage for the month for covered part D drugs under a prescription drug plan under part D of subchapter XVIII, or under an MA-PD plan under part C of subchapter XVIII; and

(ii) is determined eligible by the State for medical assistance for full benefits under this subchapter for such month under [section 1396a\(a\)\(10\)\(A\)](#) of this title or 1396a(a)(10)(C) of this title, by reason of [section 1396a\(f\)](#) of this title, or under any other category of eligibility for medical assistance for full benefits under this subchapter, as determined by the Secretary.

(B) Treatment of medically needy and other individuals required to spend down

In applying subparagraph (A) in the case of an individual determined to be eligible by the State for medical assistance under [section 1396a\(a\)\(10\)\(C\)](#) of this title or by reason of [section 1396a\(f\)](#) of this title, the individual shall be treated as meeting the requirement of subparagraph (A)(ii) for any month if such medical assistance is provided for in any part of the month.

(d) Coordination of prescription drug benefits

(1) Medicare as primary payor

In the case of a part D eligible individual (as defined in [section 1395w-101\(a\)\(3\)\(A\)](#) of this title) who is described in subsection (c)(6)(A)(ii) of this section, notwithstanding any other provision of this subchapter, medical assistance is not available under this subchapter for such drugs (or for any cost-sharing respecting such drugs), and the rules under this subchapter relating to the provision of medical assistance for such drugs shall not apply. The provision of benefits with respect to such drugs shall not be considered as the provision of care or services under the plan under this subchapter. No payment may be made under [section 1396b\(a\)](#) of this title for prescribed drugs for which medical assistance is not available pursuant

to this paragraph.

(2) Coverage of certain excludable drugs

In the case of medical assistance under this subchapter with respect to a covered outpatient drug (other than a covered part D drug) furnished to an individual who is enrolled in a prescription drug plan under part D of subchapter XVIII or an MA-PD plan under part C of such subchapter, the State may elect to provide such medical assistance in the manner otherwise provided in the case of individuals who are not full-benefit dual eligible individuals or through an arrangement with such plan.

(e) Treatment of territories

(1) In general

In the case of a State, other than the 50 States and the District of Columbia--

(A) the previous provisions of this section shall not apply to residents of such State; and

(B) if the State establishes and submits to the Secretary a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to part D eligible individuals), the amount otherwise determined under [section 1308\(f\)](#) (as increased under [section 1308\(g\)](#)) for the State shall be increased by the amount for the fiscal period specified in paragraph (3).

(2) Plan

The Secretary shall determine that a plan is described in this paragraph if the plan--

(A) provides medical assistance with respect to the provision of covered part D drugs (as defined in [section 1395w-102\(e\)](#) of this title) to low-income part D eligible individuals;

(B) provides assurances that additional amounts received by the State that are attributable to the operation of this subsection shall be used only for such assistance and related administrative expenses and that no more than 10 percent of the amount specified in paragraph (3)(A) for the State for any fiscal period shall be used for such administrative expenses; and

(C) meets such other criteria as the Secretary may establish.

(3) Increased amount

(A) In general

The amount specified in this paragraph for a State for a year is equal to the product of--

(i) the aggregate amount specified in subparagraph (B); and

(ii) the ratio (as estimated by the Secretary) of--

(I) the number of individuals who are entitled to benefits under part A or enrolled under part B and who reside in the

State (as determined by the Secretary based on the most recent available data before the beginning of the year); to

(II) the sum of such numbers for all States that submit a plan described in paragraph (2).

(B) Aggregate amount

The aggregate amount specified in this subparagraph for--

(i) the last 3 quarters of fiscal year 2006, is equal to \$28,125,000;

(ii) fiscal year 2007, is equal to \$37,500,000; or

(iii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in [section 1395w-102\(b\)\(6\)](#) of this title for the year involved.

(4) Report

The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.

[\[FN1\]](#) So in original. Probably should be followed by a comma.

[§ 1396u-6. Medicaid Integrity Program](#)

(a) In general

There is hereby established the Medicaid Integrity Program (in this section referred to as the “Program”) under which the Secretary shall promote the integrity of the program under this subchapter by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b) of this section.

(b) Activities described

Activities described in this subsection are as follows:

(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this subchapter (or under any waiver of such plan approved under [section 1315](#) of this title) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this subchapter in a manner which is not intended under the provisions of this subchapter.

(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this subchapter, including--

(A) cost reports;

(B) consulting contracts; and

(C) risk contracts under [section 1396b\(m\)](#) of this title.

(3) Identification of overpayments to individuals or entities receiving Federal funds under this subchapter.

(4) Education or training, including at such national, State, or regional conferences as the Secretary may establish, of State or local officers, employees, or independent contractors responsible for the administration or the supervision of the administration of the State plan under this subchapter, providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

(c) Eligible entity and contracting requirements

(1) In general

An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) of this section if the entity satisfies the requirements of paragraphs (2) and (3).

(2) Eligibility requirements

The requirements of this paragraph are the following:

(A) The entity has demonstrated capability to carry out the activities described in subsection (b) of this section.

(B) In carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this subchapter and in other cases arising out of such activities.

(C) The entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

(D) The entity meets such other requirements as the Secretary may impose.

(3) Contracting requirements

The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(A) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(B) Competitive procedures to be used--

(i) when entering into new contracts under this section;

(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(iii) at any other time considered appropriate by the Secretary.

(C) Procedures under which a contract under this section may be renewed without regard to any provision of law requir-

ing competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(4) Limitation on contractor liability

The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in [section 1320c-6](#) of this title.

(d) Comprehensive plan for program integrity

(1) 5-year plan

With respect to the 5-fiscal year period beginning with fiscal year 2006, and each such 5-fiscal year period that begins thereafter, the Secretary shall establish a comprehensive plan for ensuring the integrity of the program established under this subchapter by combatting fraud, waste, and abuse.

(2) Consultation

Each 5-fiscal year plan established under paragraph (1) shall be developed by the Secretary in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this subchapter.

(e) Appropriation

(1) In general

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section, without further appropriation--

(A) for fiscal year 2006, \$5,000,000;

(B) for each of fiscal years 2007 and 2008, \$50,000,000; and

(C) for each fiscal year thereafter, \$75,000,000.

(2) Availability; authority for use of funds.--

(A) Availability.

Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

(B) Authority for use of funds for transportation and travel expenses for attendees at education, training, or consultative activities.

(i) In general.

The Secretary may use amounts appropriated pursuant to paragraph (1) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of Title 5 while away from their homes or regular places of business, of individuals described in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

(ii) Public disclosure

The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public--

(I) the total amount of funds expended for each conference conducted under the authority of subsection (b)(4); and

(II) the amount of funds expended for each such conference that were for transportation and for travel expenses.

(3) Increase in CMS staffing devoted to protecting Medicaid program integrity

From the amounts appropriated under paragraph (1), the Secretary shall increase by 100 the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse.

(4) Annual report

Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies--

(A) the use of funds appropriated pursuant to paragraph (1); and

(B) the effectiveness of the use of such funds.

§ 1396u-7. State flexibility in benefit packages

(a) State option of providing benchmark benefits

(1) Authority

(A) In general

Notwithstanding [section 1396a\(a\)\(1\)](#) of this title (relating to statewideness), [section 1396a\(a\)\(10\)\(B\)](#) of this title (relating to comparability) and any other provision of this subchapter which would be directly contrary to the authority under this section and subject to subsection (E), a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to individuals within one or more groups of individuals specified by the State through coverage that--

(i) provides benchmark coverage described in subsection (b)(1) of this section or benchmark equivalent coverage described in subsection (b)(2) of this section; and

(ii) for any individual described in [section 1396d\(a\)\(4\)\(B\)](#) of this title who is eligible under the State plan in accor-

dance with paragraphs (10) and (17) of [section 1396a\(a\)](#) of this title, consists of the items and services described in [section 1396d\(a\)\(4\)\(B\)](#) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in [section 1396d\(r\)](#) of this title) and provided in accordance with the requirements of [section 1396a\(a\)\(43\)](#) of this title.

(B) Limitation

The State may only exercise the option under subparagraph (A) for an individual eligible under an eligibility category that had been established under the State plan on or before February 8, 2006.

(C) Option of additional benefits

In the case of coverage described in subparagraph (A), a State, at its option, may provide such additional benefits as the State may specify.

(D) Treatment as medical assistance

Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of [section 1396d\(a\)](#) of this title.

(E) Rule of construction

Nothing in this paragraph shall be construed as--

- (i) requiring a State to offer all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2);
- (ii) preventing a State from offering all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); or
- (iii) affecting a child's entitlement to care and services described in [subsections \(a\)\(4\)\(B\)](#) and [\(r\) of section 1396d](#) of this title and provided in accordance with [section 1396a\(a\)\(43\)](#) of this title whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.

(2) Application

(A) In general

Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this subchapter through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within 1 or more groups of such individuals.

(B) Limitation on application

A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

- (i) Mandatory pregnant women

The individual is a pregnant woman who is required to be covered under the State plan under [section 1396a\(a\)\(10\)\(A\)\(i\)](#) of this title.

(ii) Blind or disabled individuals

The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under subchapter XVI of this chapter on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of [section 1396a\(e\)\(3\)](#) of this title.

(iii) Dual eligibles

The individual is entitled to benefits under any part of subchapter XVIII of this chapter.

(iv) Terminally ill hospice patients

The individual is terminally ill and is receiving benefits for hospice care under this subchapter.

(v) Eligible on basis of institutionalization

The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(vi) Medically frail and special medical needs individuals

The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).

(vii) Beneficiaries qualifying for long-term care services

The individual qualifies based on medical condition for medical assistance for long-term care services described in [section 1396p\(c\)\(1\)\(C\)](#) of this title.

(viii) Children in foster care receiving child welfare services and children receiving foster care or adoption assistance

The individual is an individual with respect to whom child welfare services are made available under part B of subchapter IV of this chapter on the basis of being a child in foster care or with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age.

(ix) TANF and section 1396u-1 parents

The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of subchapter IV of this chapter (as in effect on or after the welfare reform effective date defined in [section 1396u-1\(i\)](#) of this title).

(x) Women in the breast or cervical cancer program

The individual is a woman who is receiving medical assistance by virtue of the application of [sections 1396a\(a\)\(10\)\(A\)\(ii\)\(XVIII\)](#) of this title and 1396a(aa) of this title.

(xi) Limited services beneficiaries

The individual--

(I) qualifies for medical assistance on the basis of [section 1396a\(a\)\(10\)\(A\)\(ii\)\(XII\)](#) of this title; or

(II) is not a qualified alien (as defined in [section 1641 of Title 8](#)) and receives care and services necessary for the treatment of an emergency medical condition in accordance with [section 1396b\(v\)](#) of this title.

(C) Full-benefit eligible individuals

(i) In general

For purposes of this paragraph, subject to clause (ii), the term “full-benefit eligible individual” means for a State for a month an individual who is determined eligible by the State for medical assistance for all services defined in [section 1396d\(a\)](#) of this title which are covered under the State plan under this subchapter for such month under [section 1396a\(a\)\(10\)\(A\)](#) of this title or under any other category of eligibility for medical assistance for all such services under this subchapter, as determined by the Secretary.

(ii) Exclusion of medically needy and spend-down populations

Such term shall not include an individual determined to be eligible by the State for medical assistance under [section 1396a\(a\)\(10\)\(C\)](#) of this title or by reason of [section 1396a\(f\)](#) of this title or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

(b) Benchmark benefit packages

(1) In general

For purposes of subsection (a)(1) of this section, each of the following coverages shall be considered to be benchmark coverage:

(A) FEHBP-equivalent health insurance coverage

The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under [section 8903\(1\) of Title 5](#).

(B) State employee coverage

A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(C) Coverage offered through HMO

The health insurance coverage plan that--

(i) is offered by a health maintenance organization (as defined in [section 300gg-91\(b\)\(3\)](#) of this title), and

(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(D) Secretary-approved coverage

Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.

(2) Benchmark-equivalent coverage

For purposes of subsection (a)(1) of this section, coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

(A) Inclusion of basic services

The coverage includes benefits for items and services within each of the following categories of basic services:

- (i) Inpatient and outpatient hospital services.
- (ii) Physicians' surgical and medical services.
- (iii) Laboratory and x-ray services.
- (iv) Well-baby and well-child care, including age-appropriate immunizations.
- (v) Other appropriate preventive services, as designated by the Secretary.

(B) Aggregate actuarial value equivalent to benchmark package

The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

(C) Substantial actuarial value for additional services included in benchmark package

With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

- (i) Coverage of prescription drugs.
- (ii) Mental health services.
- (iii) Vision services.
- (iv) Hearing services.

(3) Determination of actuarial value

The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared--

- (A) by an individual who is a member of the American Academy of Actuaries;
- (B) using generally accepted actuarial principles and methodologies;
- (C) using a standardized set of utilization and price factors;
- (D) using a standardized population that is representative of the population involved;
- (E) applying the same principles and factors in comparing the value of different coverage (or categories of services);
- (F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- (G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(4) Coverage of rural health clinic and FQHC services

Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless--

- (A) the individual has access, through such coverage or otherwise, to services described in [subparagraphs \(B\) and \(C\) of section 1396d\(a\)\(2\)](#) of this title; and
- (B) payment for such services is made in accordance with the requirements of [section 1396a\(bb\)](#) of this title.

(c) Publication of provisions affected

With respect to a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b) that is approved by the Secretary, the Secretary shall publish on the Internet website of the Centers for Medicare & Medicaid Services, a list of the provisions of this title that the Secretary has determined do not apply in order to enable the State to carry out the plan amendment and the reason for each such determination on the date such approval is made, and shall publish such list in the Federal Register and not later than 30 days after such date of approval.

§ 1396u-8. Health opportunity accounts

(a) Authority

(1) In general

Notwithstanding any other provision of this subchapter, the Secretary shall establish a demonstration program under which States may provide under their State plans under this subchapter (including such a plan operating under a statewide waiver under [section 1315](#) of this title) in accordance with this section for the provision of alternative benefits consistent with subsection (c) of this section for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a “State demonstration program”.

(2) Initial demonstration

(A) In general

The demonstration program under this section shall begin on January 1, 2007. During the first 5 years of such program, the Secretary shall not approve more than 10 States to conduct demonstration programs under this section, with each State demonstration program covering 1 or more geographic areas specified by the State. After such 5-year period--

(i) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that a State demonstration program previously implemented has been unsuccessful, such a demonstration program may be extended or made permanent in the State; and

(ii) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that all State demonstration programs previously implemented were unsuccessful, other States may implement State demonstration programs.

(B) GAO report

(i) In general

Not later than 3 months after the end of the 5-year period described in subparagraph (A), the Comptroller General of the United States shall submit a report to Congress evaluating the demonstration programs conducted under this section during such period.

(ii) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Comptroller General of the United States, \$550,000 for the period of fiscal years 2007 through 2010 to carry out clause (i).

(3) Approval

The Secretary shall not approve a State demonstration program under paragraph (1) unless the program includes the following:

- (A) Creating patient awareness of the high cost of medical care.
- (B) Providing incentives to patients to seek preventive care services.
- (C) Reducing inappropriate use of health care services.
- (D) Enabling patients to take responsibility for health outcomes.

(E) Providing enrollment counselors and ongoing education activities.

(F) Providing transactions involving health opportunity accounts to be conducted electronically and without cash.

(G) Providing access to negotiated provider payment rates consistent with this section.

Nothing in this section shall be construed as preventing a State demonstration program from providing incentives for patients obtaining appropriate preventive care (as defined for purposes of [section 223\(c\)\(2\)\(C\) of Title 26](#)), such as additional account contributions for an individual demonstrating healthy prevention practices.

(4) No requirement for Statewideness

Nothing in this section or any other provision of law shall be construed to require that a State must provide for the implementation of a State demonstration program on a Statewide basis.

(b) Eligible population groups

(1) In general

A State demonstration program under this section shall specify the eligible population groups consistent with paragraphs (2) and (3).

(2) Eligibility limitations during initial demonstration period

During the initial 5 years of the demonstration program under this section, a State demonstration program shall not apply to any of the following individuals:

(A) Individuals who are 65 years of age or older.

(B) Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this subchapter is based on such disability.

(C) Individuals who are eligible for medical assistance under this subchapter only because they are (or were within the previous 60 days) pregnant.

(D) Individuals who have been eligible for medical assistance for a continuous period of less than 3 months.

(3) Additional limitations

A State demonstration program shall not apply to any individual within a category of individuals described in [section 1396u-7\(a\)\(2\)\(B\)](#) of this title.

(4) Limitations

(A) State option

This subsection shall not be construed as preventing a State from further limiting eligibility.

(B) On enrollees in Medicaid managed care organizations

Insofar as the State provides for eligibility of individuals who are enrolled in Medicaid managed care organizations, such individuals may participate in the State demonstration program only if the State provides assurances satisfactory to the Secretary that the following conditions are met with respect to any such organization:

- (i)** In no case may the number of such individuals enrolled in the organization who participate in the program exceed 5 percent of the total number of individuals enrolled in such organization.
- (ii)** The proportion of enrollees in the organization who so participate is not significantly disproportionate to the proportion of such enrollees in other such organizations who participate.
- (iii)** The State has provided for an appropriate adjustment in the per capita payments to the organization to account for such participation, taking into account differences in the likely use of health services between enrollees who so participate and enrollees who do not so participate.

(5) Voluntary participation

An eligible individual shall be enrolled in a State demonstration program only if the individual voluntarily enrolls. Except in such hardship cases as the Secretary shall specify, such an enrollment shall be effective for a period of 12 months, but may be extended for additional periods of 12 months each with the consent of the individual.

(6) 1-year moratorium for reenrollment

An eligible individual who, for any reason, is disenrolled from a State demonstration program conducted under this section shall not be permitted to reenroll in such program before the end of the 1-year period that begins on the effective date of such disenrollment.

(c) Alternative benefits**(1) In general**

The alternative benefits provided under this section shall consist, consistent with this subsection, of at least--

- (A)** coverage for medical expenses in a year for items and services for which benefits are otherwise provided under this subchapter after an annual deductible described in paragraph (2) has been met; and
- (B)** contribution into a health opportunity account.

Nothing in subparagraph (A) shall be construed as preventing a State from providing for coverage of preventive care (referred to in subsection (a)(3) of this section) within the alternative benefits without regard to the annual deductible.

(2) Annual deductible

The amount of the annual deductible described in paragraph (1)(A) shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the health opportunity account under subsection (d)(2)(A)(i) of this section, determined without regard to any limitation described in subsection (d)(2)(C)(i)(II) of this section.

(3) Access to negotiated provider payment rates

(A) Fee-for-service enrollees

In the case of an individual who is participating in a State demonstration program and who is not enrolled with a Medicaid managed care organization, the State shall provide that the individual may obtain demonstration program Medicaid services from--

- (i) any participating provider under this subchapter at the same payment rates that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable; or
- (ii) any other provider at payment rates that do not exceed 125 percent of the payment rate that would be applicable to such services furnished by a participating provider under this subchapter if the deductible described in paragraph (1)(A) was not applicable.

(B) Treatment under Medicaid managed care plans

In the case of an individual who is participating in a State demonstration program and is enrolled with a Medicaid managed care organization, the State shall enter into an arrangement with the organization under which the individual may obtain demonstration program Medicaid services from any provider described in clause (ii) of subparagraph (A) at payment rates that do not exceed the payment rates that may be imposed under that clause.

(C) Computation

The payment rates described in subparagraphs (A) and (B) shall be computed without regard to any cost sharing that would be otherwise applicable under [sections 1396o](#) and [1396o-1](#) of this title.

(D) Definitions

For purposes of this paragraph:

- (i) The term “demonstration program Medicaid services” means, with respect to an individual participating in a State demonstration program, services for which the individual would be provided medical assistance under this subchapter but for the application of the deductible described in paragraph (1)(A).
- (ii) The term “participating provider” means--
 - (I) with respect to an individual described in subparagraph (A), a health care provider that has entered into a participation agreement with the State for the provision of services to individuals entitled to benefits under the State plan; or
 - (II) with respect to an individual described in subparagraph (B) who is enrolled in a Medicaid managed care organization, a health care provider that has entered into an arrangement for the provision of services to enrollees of the organization under this subchapter.

(4) No effect on subsequent benefits

Except as provided under paragraphs (1) and (2), alternative benefits for an eligible individual shall consist of the benefits otherwise provided to the individual, including cost sharing relating to such benefits.

(5) Overriding cost sharing and comparability requirements for alternative benefits

The provisions of this subchapter relating to cost sharing for benefits (including [sections 1396o](#) and [1396o-1](#) of this title) shall not apply with respect to benefits to which the annual deductible under paragraph (1)(A) applies. The provisions of [section 1396a\(a\)\(10\)\(B\)](#) of this title (relating to comparability) shall not apply with respect to the provision of alternative benefits (as described in this subsection).

(6) Treatment as medical assistance

Subject to subparagraphs (D) and (E) of subsection (d)(2) of this section, payments for alternative benefits under this section (including contributions into a health opportunity account) shall be treated as medical assistance for purposes of [section 1396b\(a\)](#) of this title.

(7) Use of tiered deductible and cost sharing

(A) In general

A State--

(i) may vary the amount of the annual deductible applied under paragraph (1)(A) based on the income of the family involved so long as it does not favor families with higher income over those with lower income; and

(ii) may vary the amount of the maximum out-of-pocket cost sharing (as defined in subparagraph (B)) based on the income of the family involved so long as it does not favor families with higher income over those with lower income.

(B) Maximum out-of-pocket cost sharing

For purposes of subparagraph (A)(ii), the term “maximum out-of-pocket cost sharing” means, for an individual or family, the amount by which the annual deductible level applied under paragraph (1)(A) to the individual or family exceeds the balance in the health opportunity account for the individual or family.

(8) Contributions by employers

Nothing in this section shall be construed as preventing an employer from providing health benefits coverage consisting of the coverage described in paragraph (1)(A) to individuals who are provided alternative benefits under this section.

(d) Health opportunity account

(1) In general

For purposes of this section, the term “health opportunity account” means an account that meets the requirements of this subsection.

(2) Contributions

(A) In general

No contribution may be made into a health opportunity account except--

(i) contributions by the State under this subchapter; and

(ii) contributions by other persons and entities, such as charitable organizations, as permitted under [section 1396b\(w\)](#) of this title.

(B) State contribution

A State shall specify the contribution amount that shall be deposited under subparagraph (A)(i) into a health opportunity account.

(C) Limitation on annual State contribution provided and permitting imposition of maximum account balance

(i) In general

A State--

(I) may impose limitations on the maximum contributions that may be deposited under subparagraph (A)(i) into a health opportunity account in a year;

(II) may limit contributions into such an account once the balance in the account reaches a level specified by the State; and

(III) subject to clauses (ii) and (iii) and subparagraph (D)(i), may not provide contributions described in subparagraph (A)(i) to a health opportunity account on behalf of an individual or family to the extent the amount of such contributions (including both State and Federal shares) exceeds, on an annual basis, \$2,500 for each individual (or family member) who is an adult and \$1,000 for each individual (or family member) who is a child.

(ii) Indexing of dollar limitations

For each year after 2006, the dollar amounts specified in clause (i)(III) shall be annually increased by the Secretary by a percentage that reflects the annual percentage increase in the medical care component of the consumer price index for all urban consumers.

(iii) Budget neutral adjustment

A State may provide for dollar limitations in excess of those specified in clause (i)(III) (as increased under clause (ii)) for specified individuals if the State provides assurances satisfactory to the Secretary that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that do not exceed the aggregate contributions that would otherwise be permitted under this subparagraph.

(D) Limitations on Federal matching

(i) State contribution

A State may contribute under subparagraph (A)(i) amounts to a health opportunity account in excess of the limitations provided under subparagraph (C)(i)(III), but no Federal financial participation shall be provided under [section 1396b\(a\)](#) of this title with respect to contributions in excess of such limitations.

(ii) No FFP for private contributions

No Federal financial participation shall be provided under [section 1396b\(a\)](#) with respect to any contributions described in subparagraph (A)(ii) to a health opportunity account.

(E) Application of different matching rates

The Secretary shall provide a method under which, for expenditures made from a health opportunity account for medical care for which the Federal matching rate under [section 1396b\(a\)](#) of this title exceeds the Federal medical assistance percentage, a State may obtain payment under such section at such higher matching rate for such expenditures.

(3) Use

(A) General uses

(i) In general

Subject to the succeeding provisions of this paragraph, amounts in a health opportunity account may be used for payment of such health care expenditures as the State specifies.

(ii) General limitation

Subject to subparagraph (B)(ii), in no case shall such account be used for payment for health care expenditures that are not payment of medical care (as defined by section 213(d) of the Title 26).

(iii) State restrictions

In applying clause (i), a State may restrict payment for--

(I) providers of items and services to providers that are licensed or otherwise authorized under State law to provide the item or service and may deny payment for such a provider on the basis that the provider has been found, whether with respect to this subchapter or any other health benefit program, to have failed to meet quality standards or to have committed 1 or more acts of fraud or abuse; and

(II) items and services insofar as the State finds they are not medically appropriate or necessary.

(iv) Electronic withdrawals

The State demonstration program shall provide for a method whereby withdrawals may be made from the account for such purposes using an electronic system and shall not permit withdrawals from the account in cash.

(B) Maintenance of health opportunity account after becoming ineligible for public benefit

(i) In general

Notwithstanding any other provision of law, if an account holder of a health opportunity account becomes ineligible for benefits under this subchapter because of an increase in income or assets--

(I) no additional contribution shall be made into the account under paragraph (2)(A)(i);

(II) subject to clause (iii), the balance in the account shall be reduced by 25 percent; and

(III) subject to the succeeding provisions of this subparagraph, the account shall remain available to the account holder for 3 years after the date on which the individual becomes ineligible for such benefits for withdrawals under the same terms and conditions as if the account holder remained eligible for such benefits, and such withdrawals shall be treated as medical assistance in accordance with subsection (c)(6) of this section.

(ii) Special rules

Withdrawals under this subparagraph from an account--

(I) shall be available for the purchase of health insurance coverage; and

(II) may, subject to clause (iv), be made available (at the option of the State) for such additional expenditures (such as job training and tuition expenses) specified by the State (and approved by the Secretary) as the State may specify.

(iii) Exception from 25 percent savings to Government for private contributions

Clause (i)(II) shall not apply to the portion of the account that is attributable to contributions described in paragraph (2)(A)(ii). For purposes of accounting for such contributions, withdrawals from a health opportunity account shall first be attributed to contributions described in paragraph (2)(A)(i).

(iv) Condition for non-health withdrawals

No withdrawal may be made from an account under clause (ii)(II) unless the account holder has participated in the program under this section for at least 1 year.

(v) No requirement for continuation of coverage

An account holder of a health opportunity account, after becoming ineligible for medical assistance under this subchapter, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

(4) Administration

A State may coordinate administration of health opportunity accounts through the use of a third party administrator and reasonable expenditures for the use of such administrator shall be reimbursable to the State in the same manner as other administrative expenditures under [section 1396b\(a\)\(7\)](#) of this title.

(5) Treatment

Amounts in, or contributed to, a health opportunity account shall not be counted as income or assets for purposes of deter-

mining eligibility for benefits under this subchapter.

(6) Unauthorized withdrawals

A State may establish procedures--

(A) to penalize or remove an individual from the health opportunity account based on nonqualified withdrawals by the individual from such an account; and

(B) to recoup costs that derive from such nonqualified withdrawals.

§ 1396v. References to laws directly affecting medicaid program

(a) Authority or requirements to cover additional individuals

For provisions of law which make additional individuals eligible for medical assistance under this subchapter, see the following:

(1) AFDC

(A) [Section 602\(a\)](#)(32) of this title (relating to individuals who are deemed recipients of aid but for whom a payment is not made).

(B) [Section 602\(a\)](#)(37) of this title (relating to individuals who lose AFDC eligibility due to increased earnings).

(C) [Section 606](#)(h) of this title (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

(D) [Section 682](#)(e)(6) of this title (relating to certain individuals participating in work supplementation programs).

(2) SSI

(A) [Section 1382\(e\)](#) of this title (relating to treatment of couples sharing an accommodation in a facility).

(B) [Section 1382h](#) of this title (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

(C) [Section 1383c\(b\)](#) of this title (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

(D) [Section 1383c\(c\)](#) of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under [section 402\(d\)](#) of this title).

(E) [Section 1383c\(d\)](#) of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to early widow's or widower's insurance benefits under [section 602](#)(e) or (f) of this title).

(3) Foster care and adoption assistance

[Sections 672\(h\)](#) and [673\(b\)](#) of this title (relating to medical assistance for children in foster care and for adopted children).

(4) Refugee assistance

[Section 1522\(e\)\(5\) of Title 8](#) (relating to medical assistance for certain refugees).

(5) Miscellaneous

(A) [Section 230 of Public Law 93-66](#) (relating to deeming eligible for medical assistance certain essential persons).

(B) [Section 231 of Public Law 93-66](#) (relating to deeming eligible for medical assistance certain persons in medical institutions).

(C) [Section 232 of Public Law 93-66](#) (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

(D) Section 13(c) of [Public Law 93-233](#) (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

(E) [Section 503 of Public Law 94-566](#) (relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

(F) Section 310(b)(1) of [Public Law 96-272](#) (relating to continuing medicaid eligibility for certain recipients of Department of Veterans Affairs pensions).

(b) Additional State plan requirements

For other provisions of law that establish additional requirements for State plans to be approved under this subchapter, see the following:

(1) [Section 1382g](#) of this title (relating to requirement for operation of certain State supplementation programs).

(2) Section 212(a) of [Public Law 93-66](#) (relating to requiring mandatory minimum State supplementation of SSI benefits program).

[§ 1396w. Asset verification through access to information held by financial institutions](#)

(a) Implementation

(1) In general

Subject to the provisions of this section, each State shall implement an asset verification program described in subsection (b), for purposes of determining or redetermining the eligibility of an individual for medical assistance under the State plan under this subchapter.

(2) Plan submittal

In order to meet the requirement of paragraph (1), each State shall--

(A) submit not later than a deadline specified by the Secretary consistent with paragraph (3), a State plan amendment under this subchapter that describes how the State intends to implement the asset verification program; and

(B) provide for implementation of such program for eligibility determinations and redeterminations made on or after 6 months after the deadline established for submittal of such plan amendment.

(3) Phase-in

(A) In general

(i) Implementation in current asset verification demo States

The Secretary shall require those States specified in subparagraph (C) (to which an asset verification program has been applied before June 30, 2008) to implement an asset verification program under this subsection by the end of fiscal year 2009.

(ii) Implementation in other States

The Secretary shall require other States to submit and implement an asset verification program under this subsection in such manner as is designed to result in the application of such programs, in the aggregate for all such other States, to enrollment of approximately, but not less than, the following percentage of enrollees, in the aggregate for all such other States, by the end of the fiscal year involved:

(I) 12.5 percent by the end of fiscal year 2009.

(II) 25 percent by the end of fiscal year 2010.

(III) 50 percent by the end of fiscal year 2011.

(IV) 75 percent by the end of fiscal year 2012.

(V) 100 percent by the end of fiscal year 2013.

(B) Consideration

In selecting States under subparagraph (A)(ii), the Secretary shall consult with the States involved and take into account the feasibility of implementing asset verification programs in each such State.

(C) States specified

The States specified in this subparagraph are California, New York, and New Jersey.

(D) Construction

Nothing in subparagraph (A)(ii) shall be construed as preventing a State from requesting, and the Secretary from approving, the implementation of an asset verification program in advance of the deadline otherwise established under such subparagraph.

(4) Exemption of territories

This section shall only apply to the 50 States and the District of Columbia.

(b) Asset verification program

(1) In general

For purposes of this section, an asset verification program means a program described in paragraph (2) under which a State--

(A) requires each applicant for, or recipient of, medical assistance under the State plan under this subchapter on the basis of being aged, blind, or disabled to provide authorization by such applicant or recipient (and any other person whose resources are required by law to be disclosed to determine the eligibility of the applicant or recipient for such assistance) for the State to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act but at no cost to the applicant or recipient) from any financial institution (within the meaning of section 1101(1) of such Act) any financial record (within the meaning of section 1101(2) of such Act) held by the institution with respect to the applicant or recipient (and such other person, as applicable), whenever the State determines the record is needed in connection with a determination with respect to such eligibility for (or the amount or extent of) such medical assistance; and

(B) uses the authorization provided under subparagraph (A) to verify the financial resources of such applicant or recipient (and such other person, as applicable), in order to determine or redetermine the eligibility of such applicant or recipient for medical assistance under the State plan.

(2) Program described

A program described in this paragraph is a program for verifying individual assets in a manner consistent with the approach used by the Commissioner of Social Security under [section 1383\(e\)\(1\)\(B\)\(ii\)](#) of this title.

(c) Duration of authorization

Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act, an authorization provided to a State under subsection (b)(1) shall remain effective until the earliest of--

(1) the rendering of a final adverse decision on the applicant's application for medical assistance under the State's plan under this subchapter;

(2) the cessation of the recipient's eligibility for such medical assistance; or

(3) the express revocation by the applicant or recipient (or such other person described in subsection (b)(1), as applicable) of the authorization, in a written notification to the State.

(d) Treatment of Right to Financial Privacy Act requirements

(1) An authorization obtained by the State under subsection (b)(1) shall be considered to meet the requirements of the Right to Financial Privacy Act for purposes of section 1103(a) of such Act, and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act.

(2) The certification requirements of section 1103(b) of the Right to Financial Privacy Act shall not apply to requests by the State pursuant to an authorization provided under subsection (b)(1).

(3) A request by the State pursuant to an authorization provided under subsection (b)(1) is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act and of section 1102 of such Act, relating to a reasonable description of financial records.

(e) Required disclosure

The State shall inform any person who provides authorization pursuant to subsection (b)(1)(A) of the duration and scope of the authorization.

(f) Refusal or revocation of authorization

If an applicant for, or recipient of, medical assistance under the State plan under this subchapter (or such other person described in subsection (b)(1), as applicable) refuses to provide, or revokes, any authorization made by the applicant or recipient (or such other person, as applicable) under subsection (b)(1)(A) for the State to obtain from any financial institution any financial record, the State may, on that basis, determine that the applicant or recipient is ineligible for medical assistance.

(g) Use of contractor

For purposes of implementing an asset verification program under this section, a State may select and enter into a contract with a public or private entity meeting such criteria and qualifications as the State determines appropriate, consistent with requirements in regulations relating to general contracting provisions and with [section 1396b\(i\)\(2\)](#) of this title. In carrying out activities under such contract, such an entity shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the State were to carry out such activities directly.

(h) Technical assistance

The Secretary shall provide States with technical assistance to aid in implementation of an asset verification program under this section.

(i) Reports

A State implementing an asset verification program under this section shall furnish to the Secretary such reports concerning the program, at such times, in such format, and containing such information as the Secretary determines appropriate.

(j) Treatment of program expenses

Notwithstanding any other provision of law, reasonable expenses of States in carrying out the program under this section shall be treated, for purposes of [section 1396b\(a\)](#) of this title, in the same manner as State expenditures specified in paragraph (7) of such section.

[§ 1396w-1. Medicaid Improvement Fund](#)

(a) Establishment

The Secretary shall establish under this subchapter a Medicaid Improvement Fund (in this section referred to as the "Fund") which shall be available to the Secretary to improve the management of the Medicaid program by the Centers for Medicare & Medicaid Services, including oversight of contracts and contractors and evaluation of demonstration projects. Payments made for activities under this subsection shall be in addition to payments that would otherwise be made for such activities.

(b) Funding

(1) In general

There shall be available to the Fund, for expenditures from the Fund--

(A) for fiscal year 2014, \$10,000,000; and

(B) for each of fiscal years 2015 through 2018, \$150,000,000.

(2) Funding limitation

Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

§ 1396w-2. Authorization to receive relevant information

(a) In general

Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data directly relevant to eligibility determinations under this subchapter (including eligibility files maintained by Express Lane agencies described in [section 1396a\(e\)\(13\)\(F\)](#) of this title, information described in [paragraph \(2\)](#) or [\(3\) of section 1320b-7\(a\)](#) of this title, vital records information about births in any State, and information described in [sections 653\(i\)](#) and [1396a\(a\)\(25\)\(I\)](#) of this title) is authorized to convey such data or information to the State agency administering the State plan under this subchapter, to the extent such conveyance meets the requirements of subsection (b).

(b) Requirements for conveyance

Data or information may be conveyed pursuant to subsection (a) only if the following requirements are met:

(1) The individual whose circumstances are described in the data or information (or such individual's parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

(2) Such data or information are used solely for the purposes of--

(A) identifying individuals who are eligible or potentially eligible for medical assistance under this subchapter and enrolling or attempting to enroll such individuals in the State plan; and

(B) verifying the eligibility of individuals for medical assistance under the State plan.

(3) An interagency or other agreement, consistent with standards developed by the Secretary--

(A) prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements safeguarding privacy and data security; and

(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll individuals in the plan.

(c) Penalties for improper disclosure

(1) Civil money penalty

A private entity described in the subsection (a) that publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section is subject to a civil money penalty in an amount equal to \$10,000 for each such unauthorized publication or disclosure. The provisions of [section 1320a-7a](#) of this title (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(2) Criminal penalty

A private entity described in the subsection (a) that willfully publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section shall be fined not more than \$10,000 or imprisoned not more than 1 year, or both, for each such unauthorized publication or disclosure.

(d) Rule of construction

The limitations and requirements that apply to disclosure pursuant to this section shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under Federal law (without regard to this section).

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